Uterotonic agents for preventing postpartum haemorrhage

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Uterotonic agents for preventing postpartum haemorrhage: a network meta-analysis

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ABSTRACT

Background

Postpartum haemorrhage (PPH) is the leading cause of maternal mortality worldwide. Prophylactic uterotonic agents can prevent PPH, and are routinely recommended. The current World Health Organization (WHO) recommendation for preventing PPH is 10 IU (international units) of intramuscular or intravenous oxytocin. There are several uterotonic agents for preventing PPH but there is still uncertainty about which agent is most effective with the least side effects. This is an update of a Cochrane Review which was first published in April 2018 and was updated to incorporate results from a recent large WHO trial.

Objectives

To identify the most effective uterotonic agent(s) to prevent PPH with the least side effects, and generate a ranking according to their effectiveness and side-effect profile.

Search methods

We searched the Cochrane Pregnancy and Childbirth's Trials Register, ClinicalTrials.gov, the World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP) (24 May 2018), and reference lists of retrieved studies.

Selection criteria

All randomised controlled trials or cluster-randomised trials comparing the effectiveness and side effects of uterotonic agents with other uterotonic agents, placebo or no treatment for preventing PPH were eligible for inclusion. Quasi-randomised trials were excluded. Randomised trials published only as abstracts were eligible if sufficient information could be retrieved.

Data collection and analysis

At least three review authors independently assessed trials for inclusion and risk of bias, extracted data and checked them for accuracy. We estimated the relative effects and rankings for preventing PPH ≥ 500 mL and PPH ≥ 1000 mL as primary outcomes. Secondary outcomes included blood loss and related outcomes, morbidity outcomes, maternal well-being and satisfaction and side effects. Primary outcomes were also reported for pre-specified subgroups, stratifying by mode of birth, prior risk of PPH, healthcare setting, dosage, regimen and route of administration. We performed pairwise meta-analyses and network meta-analysis to determine the relative effects and rankings of all available agents.

Main results

The network meta-analysis included 196 trials (135,559 women) involving seven uterotonic agents and placebo or no treatment, conducted across 53 countries (including high-, middle- and low-income countries). Most trials were performed in a hospital setting (187/196, 95.4%) with women undergoing a vaginal birth (71.5%, 140/196).

Relative effects from the network meta-analysis suggested that all agents were effective for preventing PPH ≥ 500 mL when compared with placebo or no treatment. The three highest ranked uterotonic agents for prevention of PPH ≥ 500 mL were ergometrine plus oxytocin combination, misoprostol plus oxytocin combination and carbetocin. There is evidence that ergometrine plus oxytocin (RR 0.70, 95% CI 0.59 to 0.84, moderate certainty), carbetocin (RR 0.72, 95% CI 0.56 to 0.93, moderate certainty) and misoprostol plus oxytocin (RR 0.70, 95% CI 0.58 to 0.86, low certainty) may reduce PPH ≥ 500 mL compared with oxytocin. Low-certainty evidence suggests that misoprostol, injectable prostaglandins, and ergometrine may make little or no difference to this outcome compared with oxytocin.

All agents except ergometrine and injectable prostaglandins were effective for preventing PPH ≥ 1000 mL when compared with placebo or no treatment. High-certainty evidence suggests that ergometrine plus oxytocin (RR 0.83, 95% CI 0.66 to 1.03) and misoprostol plus oxytocin (RR 0.88, 95% CI 0.70 to 1.11) make little or no difference in the outcome of PPH ≥ 1000 mL compared with oxytocin. Low-certainty evidence suggests that ergometrine may make little or no difference to this outcome compared with oxytocin meanwhile the evidence on carbetocin was of very low certainty. High-certainty evidence suggests that misoprostol is less effective in preventing PPH ≥ 1000 mL when compared with oxytocin (RR 1.19, 95% CI 1.01 to 1.42). Despite the comparable relative treatment effects between all uterotonics (except misoprostol) and oxytocin, ergometrine plus oxytocin, misoprostol plus oxytocin combinations and carbetocin were the highest ranked agents for PPH ≥ 1000 mL.

Misoprostol plus oxytocin reduces the use of additional uterotonics (RR 0.56, 95% CI 0.42 to 0.73, high certainty) and probably also reduces the risk of blood transfusion (RR 0.51, 95% CI 0.37 to 0.70, moderate certainty) when compared with oxytocin. Carbetocin, injectable prostaglandins and ergometrine plus oxytocin may also reduce the use of additional uterotonics but the certainty of the evidence is low. No meaningful differences could be detected between all agents for maternal deaths or severe morbidity as these outcomes were rare in the included randomised trials where they were reported.

The two combination regimens were associated with important side effects. When compared with oxytocin, misoprostol plus oxytocin combination increases the likelihood of vomiting (RR 2.11, 95% CI 1.39 to 3.18, high certainty) and fever (RR 3.14, 95% CI 2.20 to 4.49, moderate certainty). Ergometrine plus oxytocin increases the likelihood of vomiting (RR 2.93, 95% CI 2.08 to 4.13, moderate certainty) and may make little or no difference to the risk of hypertension, however absolute effects varied considerably and the certainty of the evidence was low for this outcome.

Subgroup analyses did not reveal important subgroup differences by mode of birth (caesarean versus vaginal birth), setting (hospital versus community), risk of PPH (high versus low risk for PPH), dose of misoprostol (≥ 600 mcg versus < 600 mcg) and regimen of oxytocin (bolus versus bolus plus infusion versus infusion only).

Authors' conclusions

All agents were generally effective for preventing PPH when compared with placebo or no treatment. Ergometrine plus oxytocin combination, carbetocin, and misoprostol plus oxytocin combination may have some additional desirable effects compared with the

current standard oxytocin. The two combination regimens, however, are associated with significant side effects. Carbetocin may be more effective than oxytocin for some outcomes without an increase in side effects.

PLAIN LANGUAGE SUMMARY

Which drug is best for reducing excessive blood loss after birth?

What is the issue?

The aim of this Cochrane Review was to find out which drug is most effective in preventing excessive blood loss at childbirth and has the least side effects. We collected and analysed all the relevant studies to answer this question (date of search: 24 May 2018).

Why is this important?

Excessive bleeding after birth is the most common reason why mothers die in childbirth worldwide. Although most women will have moderate bleeding at birth, others may bleed excessively, and this can pose a serious risk to their health and life. To reduce excessive bleeding at birth, the routine administration of a drug to contract the uterus (uterotonic) has become standard practice across the world.

Different drugs given routinely at birth have been used for reducing excessive bleeding. They include oxytocin, misoprostol, ergometrine, carbetocin, injectable prostaglandins and combinations of these drugs, each with different effectiveness and side effects. Some of the side effects identified include: vomiting, high blood pressure and fever. Currently, oxytocin is recommended as the standard drug to reduce excessive bleeding. We analysed all the available evidence to compare the effectiveness and side-effect profiles for each drug.

What evidence did we find?

We found 196 studies involving 135,559 women. We compared seven uterotonic agents against each other and against women receiving no uterotonic. Studies were conducted across 53 countries. In most studies women were giving birth normally and in a hospital.

The analysis suggests that all drugs are effective for preventing blood loss that equals or exceeds 500 mL when compared with no routine uterotonic treatment. Compared with oxytocin (the standard recommended drug), the three best drugs for this outcome were a combination of ergometrine plus oxytocin, carbetocin, and a combination of misoprostol plus oxytocin. We found the other drugs misoprostol, injectable prostaglandins, and ergometrine may make little or no difference to this outcome compared with oxytocin.

All drugs except ergometrine and injectable prostaglandins are effective for preventing blood loss that equals or exceeds 1000 mL when compared with no treatment. Ergometrine plus oxytocin and misoprostol plus oxytocin make little or no difference in this outcome compared with oxytocin. It is uncertain whether carbetocin and ergometrine alone make any difference to this outcome. However, misoprostol is less effective in preventing blood loss that equals or exceeds 1000 mL compared with oxytocin.

Misoprostol plus oxytocin reduces the use of additional uterotonics and probably also reduces the risk of blood transfusion when compared with oxytocin. Carbetocin, injectable prostaglandins and ergometrine plus oxytocin may also reduce the use of additional uterotonics but the certainty of the evidence is low. No meaningful differences could be detected between all agents for maternal deaths or severe birth complication as these are rare in such studies.

The two combinations of drugs were associated with important side effects. When compared with oxytocin, women receiving misoprostol plus oxytocin combination are more likely to suffer vomiting and fever. Women receiving ergometrine plus oxytocin are also more likely to suffer vomiting and may make little or no difference to the risk of hypertension, however the certainty of the evidence was low for this outcome.

The analyses gave similar results irrespective of whether women were giving birth normally or by caesarean, in a hospital or in the community, were at high or low risk for bleeding excessively after birth, whether they received a high or a low dose of misoprostol and whether they received a bolus or an infusion of oxytocin or both.

What does this mean?

All agents were generally effective for preventing excessive bleeding when compared with no uterotonic drug treatment. Ergometrine plus oxytocin combination, carbetocin, and misoprostol plus oxytocin combination may have some additional benefits compared with the current standard oxytocin. The two combination drugs, however, are associated with significant side effects that women might find

disturbing compared with oxytocin. Carbetocin may have some additional benefits compared with oxytocin and appears to be without an increase in side effects.

SUMMARY OF FINDINGS FOR THE MAIN COMPARISON *[Explanation]*

Patient or population: women in the third stage of labour
Interventions: carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin
Comparison (reference): oxytocin
Outcome: PPH ≥ 500 mL
Setting: hospital or community setting

Uterotonic agent(s)	Direct evidence		Indirect evidence		NMA evidence		Anticipated absolute effects for NMA estimate		
	RR (95% CI)	Certainty	RR (95% CI)	Certainty	RR (95% CI)	Certainty	Risk with oxytocin	Risk with intervention (other uterotonics)	Risk difference with intervention
Carbetocin	0.75 (0.58 to 0.98)	⊕⊕⊕◯ MODERATE [a]	0.59 (0.31 to 1.12)	⊕⊕◯◯ LOW [b]	0.72 (0.56 to 0.93)	⊕⊕⊕◯ MODERATE [c]	145 per 1000	104 per 1000	41 fewer per 1000 (from 64 fewer to 10 fewer)
							Vaginal birth: 122 per 1000	Vaginal birth:87 per 1000	Vaginal birth: 34 fewer per 1000 (from 54 fewer to 9 fewer)
							Caesarean birth: 604 per 1000	Caesarean birth: 435 per 1000	Caesarean birth: 169 fewer per 1000 (from 266 fewer to 42 fewer)
Misoprostol	1.08 (0.94 to 1.24)	⊕⊕◯◯ LOW [d]	1.07 (0.83 to 1.39)	⊕◯◯◯ VERY LOW [e]	1.08 (0.96 to 1.22)	⊕⊕◯◯ LOW [f]	145 per 1000	157 per 1000	12 more per 1000 (4 fewer to 32 more)

							Vaginal birth: 122 per 1000	Vaginal birth: 132 per 1000	Vaginal birth:10 more per 1000 (4 fewer to 27 more)
							Caesarean birth: 604 per 1000	Caesarean birth: 652 per 1000	Caesarean birth: 48 more per 1000 (18 fewer to 133 more)
Injectable prostaglandin	0.84 (0.26 to 2.71)	⊕⊕◯◯ LOW [g]	1.08 (0.72 to 1.62)	⊕◯◯◯ VERY LOW [e]	1.05 (0.73 to 1.51)	⊕⊕◯◯ LOW [f]	145 per 1000	152 per 1000	7 more per 1000 (39 fewer to 74 more)
							Vaginal birth: 122 per 1000	Vaginal birth: 128 per 1000	Vaginal birth:6 more per 1000 (33 fewer to 62 more)
							Caesarean birth: 604 per 1000	Caesarean birth: 634 per 1000	Caesarean birth: 30 more per 1000 (163 fewer to 308 more)
Ergometrine	1.31 (0.86 to 1.99)	⊕◯◯◯ VERY LOW [h]	0.96 (0.70 to 1.31)	⊕⊕◯◯ LOW [i]	1.09 (0.85 to 1.39)	⊕⊕◯◯ LOW [j]	145 per 1000	158 per 1000	13 more per 1000 (22 fewer to 57 more)
							Vaginal birth: 122 per 1000	Vaginal birth: 133 per 1000	Vaginal birth: 11 more per 1000 (18 fewer to 48 more)

							Caesarean birth: 604 per 1000	Caesarean birth: 610 per 1000	Caesarean birth: 6 more per 1000 (91 fewer to 236 more)
Ergometrine plus oxytocin	0.72 (0.57 to 0.91)	⊕⊕⊕◯ MODERATE [k]	0.69 (0.54 to 0.90)	⊕⊕◯◯ LOW [b]	0.70 (0.59 to 0.84)	⊕⊕⊕◯ MODERATE [c]	145 per 1000	101 per 1000	44 fewer per 1000 (59 fewer to 23 fewer)
							Vaginal birth: 122 per 1000	Vaginal birth: 85 per 1000	Vaginal birth: 37 fewer per 1000 (50 fewer to 20 fewer)
							Caesarean birth: 604 per 1000	Caesarean birth: 423 per 1000	Caesarean birth: 181 fewer per 1000 (248 fewer to 97 fewer)
Misoprostol plus oxytocin	0.71 (0.59 to 0.85)	⊕⊕◯◯ LOW [l]	0.79 (0.35 to 1.77)	⊕⊕◯◯ LOW [i]	0.70 (0.58 to 0.86)	⊕⊕◯◯ LOW [m]	145 per 1000	101 per 1000	44 fewer per 1000 (61 fewer to 20 fewer)
							Vaginal birth: 122 per 1000	Vaginal birth: 85 per 1000	Vaginal birth: 37 fewer per 1000 (51 fewer to 17 fewer)
							Caesarean birth: 604 per 1000	Caesarean birth: 423 per 1000	Caesarean birth: 181 fewer per 1000 (254 fewer to 85 fewer)

The assumed risks in the oxytocin group are based on weighted means of baseline risks from the studies with oxytocin groups in the network meta-analysis.**The corresponding risks in the carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin groups** (and their 95% confidence interval) are based on the assumed risk in the oxytocin group and the **relative effect** of individual uterotonic when compared with oxytocin (and its 95% CI) derived from the network meta-analysis

* No included studies or there are no event in included studies to estimate the baseline risk

** Absolute risk with uterotonic cannot be estimated in the absence of absolute risk with oxytocin

*** Risk difference cannot be estimated in the absence of absolute risks with intervention and oxytocin

CI: Confidence interval; **RR:** Risk ratio.

GRADE Working Group grades of evidence

High certainty: We are very confident that the true effect lies close to that of the estimate of the effect

Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

[a] Direct evidence downgraded -1 due to severe unexplained statistical heterogeneity

[b] Indirect evidence downgraded -2 due to multiple limitations in study design and severe unexplained statistical heterogeneity

[c] Network evidence downgraded -1 due to moderate certainty direct evidence (no intransitivity, incoherence, or imprecision)

[d] Direct evidence downgraded -2 due to multiple crucial limitations in study design

[e] Indirect evidence downgraded -3 due to multiple crucial limitations in study design, severe unexplained statistical heterogeneity and serious imprecision

[f] Network evidence downgraded -2 due to low certainty direct evidence (no intransitivity or incoherence, network estimate remains imprecise)

[g] Direct evidence downgraded -2 due to multiple limitations in study design and serious imprecision

[h] Direct evidence downgraded -3 due to multiple crucial limitations in study design and serious imprecision

[i] Indirect evidence downgraded -2 due to severe unexplained statistical heterogeneity, multiple limitations in study design and serious imprecision

[j] Network evidence downgraded -2 due to low certainty indirect evidence (no intransitivity or incoherence, network estimate remains imprecise)

[k] Direct evidence downgraded -1 due to multiple limitations in study design

[l] Direct evidence downgraded -2 due to multiple limitations in study design and strong suspicion of publication bias

[m] Network evidence downgraded -2 due to low certainty direct and indirect evidence (no intransitivity, incoherence, or imprecision)

BACKGROUND

Description of the condition

An estimated 303,000 women died during childbirth in 2015 (Alkema 2016). Postpartum haemorrhage (PPH) accounted for up to a third of all these maternal deaths (Say 2014). Almost all deaths occurred in low- or middle-income countries. Even when death from PPH is avoided, the need for blood transfusion, hysterectomy and additional intervention place a huge burden on women's health and health services (Penney 2007; Souza 2013).

The third stage of labour, defined as the period of time from birth until the delivery of the placenta, and the immediate postpartum period are the most hazardous periods of childbirth due to the risk of PPH. The World Health Organization (WHO) defines PPH as when the blood loss after birth equals or exceeds 500 mL in the first 24 hours (WHO 2012). The most common cause of PPH is uterine atony (failure of the uterus to contract after birth). Even though risk factors for adverse maternal outcomes from severe haemorrhage have been identified (Souza 2013), often PPH is unpredictable as it occurs in the absence of identifiable clinical or historical risk factors (Combs 1991). Therefore, effective prevention of PPH is advocated for all women during childbirth (WHO 2012). The administration of uterotonic agents routinely in the third stage of labour is the key intervention that prevents PPH, although there is uncertainty about which agent may be the most effective.

Description of the intervention

The administration of uterotonic agents to prevent PPH is part of the active management of the third stage of labour (Begley 2015). The active management of the third stage of labour refers to the administration of a uterotonic agent, early cord clamping, and controlled cord traction until delivery of the placenta. In 2012, a WHO guideline panel revisited the evidence underpinning each component of active management of the third stage of labour and considered the use of uterotonics as the main intervention within this package (WHO 2012).

How the intervention might work

Several different uterotonic agents have been used for preventing PPH. These agents include ergometrine, misoprostol, carbetocin, oxytocin, injectable prostaglandins (such as carboprost and sulprostone) and the combinations of agents such as misoprostol plus oxytocin and ergometrine plus oxytocin.

Oxytocin

Oxytocin (Syntocinon®) is the most widely used uterotonic agent. At low doses, it produces rhythmic uterine contractions that are indistinguishable in frequency, force and duration from those observed during spontaneous labour, but at higher dosages, it causes sustained uterine contractions (MEDICINES.ORG.UK). It has a short half-life, approximately three to five minutes, and can be used as an infusion to maintain uterine contraction. When used intramuscularly, the latent phase lasts three to seven minutes, but produces a longer-lasting clinical effect of up to one hour (MEDICINES.ORG.UK). However, oxytocin cannot be used orally. It is unstable in ambient temperatures and it requires a cold chain through storage and transport. It should also not be given intravenously as a large bolus, because it can cause severe hypotension (Thomas 2007). Because of its anti-diuretic effect, water intoxication can occur with prolonged infusion of oxytocin (MEDICINES.ORG.UK).

Ergometrine

Ergometrine and methylergometrine are ergot alkaloids that increase the uterine muscle tone by causing sustained uterine contractions. They have a latent phase of two to five minutes after intramuscular injection and the plasma half-life is 30 to 120 minutes (de Groot 1998). After intravenous administration, the onset of action is one minute or less and the duration of action is 45 minutes (although rhythmic contractions may persist for up to three hours). However, ergometrine and methylergometrine have an unpredictable bioavailability, which prevents oral use of the agent and requires protection from light, and storage at a temperature between 2° and 8°C to prolong shelf life (de Groot 1996a). They are vasoconstrictive and are contraindicated in women with hypertensive or cardiovascular disorders (MEDICINES.ORG.UK).

Misoprostol

Misoprostol is a prostaglandin E1 analogue, which is licensed for the prevention and treatment of gastric ulcers. It is well known for its off-label use as a uterotonic agent (Tuncalp 2012). It is water-soluble and heat stable (Davies 2001). It is absorbed nine to 15 minutes after sublingual, oral, vaginal, and rectal use. The half-life is about 20 to 40 minutes. Oral and sublingual routes have the advantage of rapid onset of action, while the vaginal and rectal routes result in prolonged activity and greater bioavailability (Schaff 2005).

Injectable prostaglandins

Prostaglandin preparations are available in injectable forms and the most commonly used agents are carboprost tromethamine (Hemabate), an analogue of 15-methyl-prostaglandin F2a, and sulprostone, which is a PGE2 analogue. After intramuscular administration, the time to peak plasma concentration is between

15 and 60 minutes. The half-life is about eight minutes. They require storage at a temperature between 2° and 8°C to prolong shelf life (MEDICINES.ORG.UK). They both enhance uterine contractility and cause vasoconstriction in postpartum women (MEDICINES.ORG.UK). However, they are not contraindicated in hypertensive women (MEDICINES.ORG.UK). In the management of the third stage of labour, injectable prostaglandins have been mainly used for intractable PPH as a last resort when other measures fail. Important disadvantages of injectable prostaglandins have been their cost and availability.

Carbetocin

Carbetocin is a newer long-acting synthetic analogue of oxytocin with agonist properties. After intravenous injection, it produces sustained uterine contractions within two minutes, lasting for approximately six minutes followed by rhythmic contractions for 60 minutes (Hunter 1992). When carbetocin is administered by an intramuscular injection, the sustained uterine contractions last for approximately 11 minutes and the rhythmic contractions for 120 minutes (Hunter 1992). A heat stable carbetocin is now available and has been evaluated against oxytocin in a large randomised trial (Widmer 2018). Carbetocin also appears to have a favourable side-effect profile (Su 2012).

Combination agents

The use of combinations of uterotonic agents is also popular and the most commonly used agent is ergometrine plus oxytocin (Syntometrine ®). This is a fixed-combination agent containing 5 international units (IU) of oxytocin and 500 mcg of ergometrine. Intramuscular injection is the recommended route (MEDICINES.ORG.UK). When used intramuscularly, the latent period for the occurrence of the uterine response is about 2.5 minutes and the uterotonic effects last for around three hours. Another combination that has been investigated is misoprostol plus oxytocin. This combination is not in synthetic (fixed-drug) or naturally occurring forms.

The WHO recommends that all women giving birth should be offered uterotonics during the third stage of labour for the prevention of PPH; oxytocin (intramuscular/intravenous, 10 IU is the uterotonic agent of choice (WHO 2012). Other injectable uterotonics and misoprostol are recommended as alternatives for the prevention of PPH in settings where oxytocin is not available.

Why it is important to do this review

The individual uterotonics described above have been compared in existing Cochrane Reviews and all comparisons are based on trials that directly compared one uterotonic against another uterotonic agent in head-to-head trials (Begley 2015; Liabsuetrakul 2018; McDonald 2004; Su 2012; Tuncalp 2012; Westhoff 2013). The existing Cochrane Reviews have variable eligibility criteria for study inclusion, uterotonic agent comparisons and outcomes. In the absence of a single randomised controlled trial comparing all available uterotonic agents, uncertainty remains over their relative effectiveness and ranking. When multiple interventions are available, a network meta-analysis is better placed for synthesising and interpreting the wider picture of the evidence and to understand the relative effects of all available interventions. Network meta-analysis has advantages over conventional pairwise meta-analysis, as the technique uses both direct and indirect evidence in a single coherent analysis to improve certainty about all possible treatment comparisons. Indirect evidence is obtained when the relative effectiveness of two competing interventions is inferred through a common comparator, even though this pair may not have been compared directly (Caldwell 2005; Lumley 2002).

This is an update of a review first published in April 2018. It has been updated to incorporate results from a large WHO trial (Widmer 2018) and a number of other large recently published trials.

OBJECTIVES

To identify the most effective uterotonic agent(s) to prevent postpartum haemorrhage (PPH) with the least side effects, and generate a ranking according to their effectiveness and side-effect profile.

METHODS

Criteria for considering studies for this review

Types of studies

All randomised controlled trials or cluster-randomised trials comparing the effectiveness and side effects of uterotonic agents with other uterotonic agents, placebo or no treatment for preventing postpartum haemorrhage (PPH) were eligible for inclusion. Quasi-randomised trials were excluded. Randomised trials published only as abstracts were eligible if sufficient information could be retrieved.

Types of participants

The review included studies of women in the third stage of labour following a vaginal or caesarean birth in hospital or community settings.

Types of interventions

Trials were eligible if they administered uterotonic agents of any dosage, route or regimen systemically at birth for preventing PPH, and compared them with other uterotonic agents, placebo or no treatment. Trials evaluating uterotonic agents not administered systemically, such as intrauterine administration, or not immediately after birth, or exclusively comparing different dosages, routes or regimens of the same uterotonic agent were excluded. We included trials in which non-pharmacologic co-interventions such as controlled cord traction, cord clamping, or uterine massage was performed as a randomised intervention in all arms of the trial and the effects of such co-interventions were tested through a sensitivity analysis.

We classified agents into single agents including oxytocin, carbetocin, injectable prostaglandins (carboprost tromethamine, sulprostone), misoprostol, ergometrine (included also ergonovine, methylergonovine), and combination agents including ergometrine plus oxytocin (Syntometrine ® as a fixed-combination agent containing 5 international units (IU) of oxytocin and 500 mcg of ergometrine, any oxytocin dose and route when combined with any dose and route of ergometrine, ergonovine, or methylergonovine), and misoprostol plus oxytocin (any oxytocin dose and route when combined with any dose and route of misoprostol).

For this review, we assumed that any woman who meets the inclusion criteria is, in principle, equally likely to be randomised to any of the eligible uterotonic agents.

Types of outcome measures

We estimated the relative effects and rankings of the competing interventions according to the following outcomes.

Primary outcomes

The primary outcomes of the review were:

1. PPH $\geq$ 500 mL; and
2. PPH $\geq$ 1000 mL.

Secondary outcomes

The secondary outcomes of the review were:

1. maternal deaths;
2. severe maternal morbidity: intensive care admissions;
3. severe maternal morbidity: shock (as defined by the trialists);
4. additional uterotonics;
5. blood transfusion;
6. mean volumes of blood loss (mL);
7. change in haemoglobin measurements before versus after birth (g/L);
8. breastfeeding at hospital discharge;
9. nausea;
10. vomiting;
11. hypertension;
12. headache;
13. fever (>= 38°C);
14. shivering;
15. abdominal pain;
16. diarrhoea;
17. maternal sense of well-being (as defined by the trialists);
18. maternal satisfaction (as defined by the trialists).

Search methods for identification of studies

Electronic searches

We searched Cochrane Pregnancy and Childbirth's Trials Register by contacting their Information Specialist (24 May 2018).

The Register is a database containing over 25,000 reports of controlled trials in the field of pregnancy and childbirth. It represents over 30 years of searching. For full current search methods used to populate Pregnancy and Childbirth's Trials Register including the detailed search strategies for CENTRAL, MEDLINE, Embase and CINAHL; the list of handsearched journals and conference proceedings, and the list of journals reviewed via the current awareness service, please follow this link

Briefly, Cochrane Pregnancy and Childbirth's Trials Register is maintained by their Information Specialist and contains trials identified from:

1. monthly searches of the Cochrane Central Register of Controlled Trials (CENTRAL);
2. weekly searches of MEDLINE (Ovid);
3. weekly searches of Embase (Ovid);
4. monthly searches of CINAHL (EBSCO);
5. handsearches of 30 journals and the proceedings of major conferences;
6. weekly current awareness alerts for a further 44 journals plus monthly BioMed Central email alerts.

Search results are screened by two people and the full text of all relevant trial reports identified through the searching activities described above is reviewed. Based on the intervention described, each trial report is assigned a number that corresponds to a specific Pregnancy and Childbirth review topic (or topics), and is then added to the Register. The Information Specialist searches the Register for each review using this topic number rather than keywords. This results in a more specific search set that has been fully accounted for in the relevant review sections (Included studies; Excluded studies; Studies awaiting classification; Ongoing studies).

In addition, we searched ClinicalTrials.gov and the WHO International Clinical Trials Registry Platform (ICTRP) for unpublished, planned and ongoing trial reports using the terms given in Appendix 1 (24 May 2018).

Searching other resources

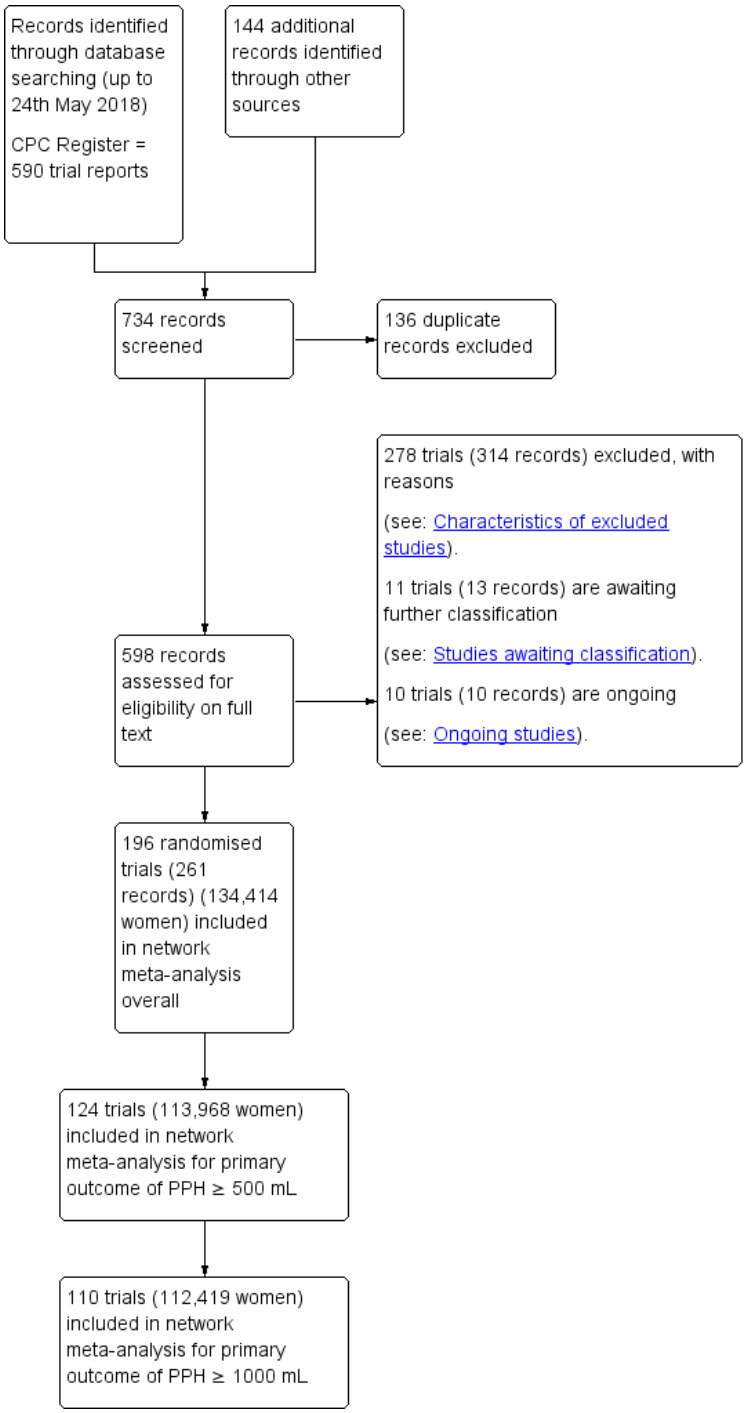
We retrieved additional relevant references cited in papers identified through the above search strategy and we did search for the full texts of trials initially identified as abstracts. For randomised trials published only as abstracts, we sought information from primary authors to investigate whether these studies met our eligibility criteria before including them. Trials that compared at least two of the agents were eligible and we searched for all possible comparisons. We did not apply any language or date restrictions.

Data collection and analysis

Selection of studies

Three review authors retrieved and independently assessed for inclusion all the potential studies we identified (IDG, AP, NA). We resolved any disagreements through discussion or, if required, in consultation with a third person (AC). We created a study flow diagram to map out the number of records identified, included and excluded (Figure 1).

Figure 1. Study flow diagram.



Data extraction and management

We designed an electronic form on ©Microsoft Access to extract data. For eligible studies, at least three review authors independently extracted the data using a blank electronic form (IDG, AP, NA, RM, OT). We resolved discrepancies through discussion or, if required, we consulted another person (AC). We entered data into STATA and Review Manager software (RevMan 2014) and checked for accuracy. When information was unclear, we attempted to contact authors of the original reports to provide further details. The following data were extracted.

Outcome data

From each included study we extracted: the number of participants, the gestational age and the parity of participants, and any exclusion criteria. We also extracted: the interventions being compared, and their respective primary and secondary outcomes. All relevant arm level data were extracted (e.g. number of events and number of patients for binary outcomes and means and standard deviations per study arm for continuous outcomes).

Data on potential effect modifiers

From each included study we extracted the following study, intervention and population characteristics that may act as effect modifiers:

1. mode of delivery (vaginal or caesarean birth);
2. prior risk of PPH (as defined by trialists and categorised as low, high, mixed or not stated);
3. dosage, regimen, and route of administration (sublingual, subcutaneous, intramuscular, rectal, oral, intravenous bolus and/or infusion); and
4. setting of the study (community or hospital).

Other data

From each included study we extracted the following additional information:

1. country or countries in which the study was performed;
2. date of publication and dates of recruitment;
3. type of publication (full-text publication, abstract publication, unpublished data); and
4. trial registration reference.

Assessment of risk of bias in included studies

At least three (IDG, AP, NA, RM) review authors independently assessed the risk of bias for each study using the criteria outlined in the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011). Any disagreements were resolved by discussion or by involving another assessor (AC).

(1) Random sequence generation (checking for possible selection bias)

Studies were excluded if found to be at high risk for bias for random sequence generation (any non-random process, e.g. odd or even date of birth; hospital or clinic record number). We described for each included study the method used to generate the allocation sequence in sufficient detail to allow an assessment of whether it should produce comparable groups.

We assessed the methods as:

- low risk of bias (any truly random process, e.g. random number table; computer random number generator); or
- unclear risk of bias.

(2) Allocation concealment (checking for possible selection bias)

We described for each included study the method used to conceal allocation to interventions prior to assignment and assessed whether intervention allocation could have been foreseen in advance of, or during recruitment, or changed after assignment.

We assessed the methods as:

- low risk of bias (e.g. telephone or central randomisation; consecutively numbered sealed opaque envelopes);
- high risk of bias (open random allocation; unsealed or non-opaque envelopes, alternation; date of birth); or
- unclear risk of bias.

(3.1) Blinding of participants and personnel (checking for possible performance bias)

We described for each included study the methods used, if any, to blind study participants and personnel from knowledge of which intervention a participant received. We considered that studies were at low risk of bias if they were blinded, or if we judged that the lack of blinding would be unlikely to have affected the results.

We assessed the methods as:

- low, high or unclear risk of bias for participants; and
- low, high or unclear risk of bias for personnel.

(3.2) Blinding of outcome assessment (checking for possible detection bias)

We described for each included study the methods used, if any, to blind outcome assessors from knowledge of which intervention a participant received.

We assessed methods used to blind outcome assessment as:

- low, high or unclear risk of bias.

(4) Incomplete outcome data (checking for possible attrition bias due to the amount, nature and handling of incomplete outcome data)

We described for each included study the completeness of data including attrition and exclusions from the analysis. We stated whether attrition and exclusions were reported and the numbers included in the analysis at each stage (compared with the total randomised participants), reasons for attrition or exclusion where reported, and whether missing data were balanced across groups or were related to outcomes. Where sufficient information was reported, or supplied by the trial authors, we re-included missing data in the analyses. We assessed methods to handle incomplete outcome data as:

- low risk of bias (e.g. no missing outcome data; missing outcome data balanced across groups and less than 10% of missing outcome data);
- high risk of bias (e.g. numbers or reasons for missing data imbalanced across groups; 'as treated' analysis done with substantial departure of intervention received from that assigned at randomisation or more than 10% of missing outcome data); or
- unclear risk of bias.

(5) Selective reporting (checking for reporting bias)

We described for each included study how we investigated the possibility of selective outcome reporting bias and what we found. We assessed the methods as:

- low risk of bias (where it is clear that all of the study's pre-specified outcomes and all expected outcomes of interest to the review have been reported);
- high risk of bias (where not all the study's pre-specified outcomes have been reported; one or more reported primary outcomes were not pre-specified; outcomes of interest are reported incompletely and so cannot be used; study fails to include results of a key outcome that would have been expected to have been reported); or
- unclear risk of bias.

(6) Other bias (checking for bias due to problems not covered by (1) to (5) above)

We described for each included study any important concerns about other possible sources of bias, such as the source of funding and potential conflicts of interest.

We assessed these interests as:

- low risk of other bias (public funding or no funding and no significant conflicts of interest identified);
- high risk of other bias (industry funding or significant conflicts of interest identified); or
- unclear risk of other bias.

Another source of bias was generated by the method of measuring blood loss. We assessed the method described in each study and classified it as at:

- low risk of other bias (objective measurements such as weighing sponges, measurements in drapes, volumetric assessment, tagged red cells, etc);
- high risk of other bias (subjective measurement such as clinical or visual estimates); or
- unclear risk of other bias (unspecified methods of measurement).

(7) Overall risk of bias

We made explicit judgements about whether studies were at high risk of bias, according to the criteria given in the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011). For our primary outcomes, we combined quality items and judged trials as "low risk of bias" if they were double-blinded, had allocation concealment and with little loss to follow-up (less than 10%). Trials were judged as "intermediate risk of bias" if they demonstrated adequate allocation concealment, with assessor blinding and little loss to follow-up (less than 10%). Alternatively, trials were considered to be at "high risk of bias". We explored the impact of the level of bias through undertaking sensitivity analyses - *see* Sensitivity analysis for information about how the risk of bias was incorporated in the sensitivity analysis.

Summary of findings

The 'Summary of findings' tables present evidence comparing all other uterotonic agents with a reference comparator, oxytocin. Each table describes key features of the evidence relating to a single outcome, and there is one table for each of our seven most important outcomes in accordance with the GRADE approach. These include PPH $\geq$ 500 mL, PPH $\geq$ 1000 mL, blood transfusion, additional uterotonics, vomiting, hypertension and fever.

We used the GRADE working group's approach (Brignardello-Petersen 2018; Puhan 2014) for rating the certainty of the network meta-analysis effect estimates for all the comparisons and all outcomes. We appraised the certainty of the direct, indirect, and network evidence sequentially (in this order). First, we assessed the certainty of the direct evidence (where available) for a given outcome, and rated the evidence using the standard GRADE approach based on consideration of: study design limitations (risk of bias); inconsistency; imprecision; indirectness and publication bias (Higgins 2011). On the network diagram for all the comparisons and all outcomes we display the certainty of the direct evidence. Then we rated the certainty of the indirect evidence for the same outcome, and this was determined based on the lower of the certainty ratings of the two arms forming the dominant 'first-order' loop in the network diagram for this outcome. Our final

step was to determine the quality of network evidence based on: (i) the higher certainty rating of the direct and indirect evidence, (ii) whether the relevant network diagram exhibited 'intransitivity', i.e. whether all the comparisons contributing data to the estimate were directly consistent with the PICO question, (iii) consideration of coherence between direct and indirect effect estimates, and (iv) precision of the network effect estimate. Where the network estimate was precise, and the direct and/or indirect evidence contributing to the certainty ratings were not, the certainty of the network evidence was upgraded by one level for precision. At each of these stages, two review authors (MJW, VD, JP, MC) independently appraised the certainty ratings for the direct, indirect and network evidence. Disagreements between authors were resolved through discussion and consultation with a third review author (OTO, JPV) where necessary.

The quality of network evidence for each outcome was rated as 'high', 'moderate', 'low' or 'very low' in accordance with the GRADE approach:

- **High certainty:** we are very confident that the true effect lies close to that of the estimate of the effect;
- **Moderate certainty:** we are moderately confident in the effect estimate. The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different;
- **Low certainty:** our confidence in the effect estimate is limited. The true effect may be substantially different from the estimate of the effect; and
- **Very low certainty:** we have very little confidence in the effect estimate. The true effect is likely to be substantially different from the estimate of effect.

For ease of comparison when interpreting the relative effects of all uterotonic agents, the 'Summary of findings' tables include the effect estimate and certainty judgements for each of the direct evidence, indirect evidence and the network meta-analysis, describing all the findings for a single outcome in each table. The anticipated absolute effects are also included, based on the network effect estimate for each agent/agent combination in comparison with oxytocin. The assumed risks in the oxytocin group are based on weighted means of baseline risks from the studies with oxytocin arms in the network meta-analysis. The corresponding risks in the carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin groups (and their 95% confidence interval (CI)) are based on the assumed risk in the oxytocin group and the relative effect of the individual uterotonic when compared with oxytocin (and its 95% CI) as derived from the network meta-analysis. The baseline risks differed significantly by the mode of birth subgroups, so the anticipated absolute effects are presented separately for vaginal and caesarean births based on the weighted means of baseline risks according to these modes of birth.

Measures of treatment effect

Relative treatment effects

We summarised relative treatment effects for dichotomous outcomes as risk ratios (RR) and for continuous outcomes as mean difference (MD) with 95% CIs (Dias 2013). These are summarised in forest plots displaying the results from pairwise, indirect and network (combining direct and indirect) analyses for the comparisons of uterotonic agents versus placebo or no treatment and the comparisons of uterotonic agents versus oxytocin. All other comparisons are available from Appendix 2.

Relative treatment ranking

We estimated the cumulative probabilities for each uterotonic agent being at each possible rank and obtained a treatment hierarchy using the surface under the cumulative ranking curve (SUCRA); the larger the SUCRA the higher its rank among all available agents (Salanti 2011). The probabilities to rank the treatments are estimated under a Bayesian model with flat priors, assuming that the posterior distribution of the parameter estimates is approximated by a normal distribution with mean and variance equal to the frequentist estimates and variance-covariance matrix. Rankings are constructed drawing 1000 samples from their approximate posterior density. For each draw, the linear predictor is evaluated for each study, and the largest linear predictor is noted (White 2011).

Unit of analysis issues

Cluster-randomised trials

For a cluster-randomised trial included in this review (Stanton 2013), we used the unadjusted standard errors as the clusters and the Intracluster Correlation Co-efficient (ICC) was small (ICC = 0.012). Another cluster-randomised trial (Chandhiok 2006) did not report the ICC and the ICC from Stanton 2013 was used. Chandhiok 2006 was reduced it to its effective sample size taking into account the design effects as described in the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011). We considered it reasonable to combine the results from the cluster-randomised and the individually-randomised trials as there was little heterogeneity between the study designs and any interaction between the relative effects of agents and the choice of randomisation unit was considered to be unlikely. The effect of the unit of randomisation was also assessed in sensitivity analysis (Higgins 2011).

Multi-arm trials

Multi-arm trials were included and we accounted for the correlation between the effect estimates in the network meta-analysis. We treated multi-arm studies as multiple independent comparisons in pairwise meta-analyses and these were not combined in any analysis.

Dealing with missing data

For included studies, we noted the levels of attrition. We explored the impact of including studies with high levels of missing data in the overall assessment of treatment effect by using sensitivity analysis. For all outcomes, we carried out analyses, as far as possible, on an intention-to-treat basis, i.e. we included all participants randomised to each group in the analyses, and all participants were analysed in the group to which they were allocated, regardless of whether or not they received the allocated intervention. We used the number randomised minus any participants whose outcomes were known to be missing as the denominator for each outcome in each trial.

Assessment of clinical and methodological heterogeneity within treatment comparisons

To evaluate the presence of clinical heterogeneity, we described the study population characteristics across all included trials. We assessed the presence of clinical heterogeneity by comparing these characteristics.

Assessment of intransitivity across treatment comparisons

In this context we expect that the intransitivity assumption holds assuming the following: 1) the common treatment used to compare different uterotonics indirectly is similar when it appears in different trials (e.g. oxytocin is administered in a similar way in oxytocin versus misoprostol trials and in oxytocin versus oxytocin plus ergometrine trials); 2) all pairwise comparisons do not differ with respect to the distribution of effect modifiers (e.g. the design and study characteristics of oxytocin versus misoprostol trials are similar to oxytocin versus oxytocin plus ergometrine trials). The assumption of intransitivity was evaluated epidemiologically by comparing the clinical and methodological characteristics of sets of studies from the various treatment comparisons.

Assessment of reporting biases

If there were 10 or more studies in the meta-analysis, we investigated reporting biases (such as publication bias) using funnel plots. The funnel plots were assessed visually for asymmetry. We also assessed potential reporting bias for the primary outcomes by assessing the sensitivity of results to exclusion of studies with fewer than 400 participants.

Data synthesis

Methods for direct treatment comparisons

Initially, we performed pairwise meta-analyses using a random-effects model in Stata and Review Manager software (RevMan 2014) for every treatment comparison with at least two studies (DerSimonian 1986).

Methods for indirect and network comparisons

We initially generated and assessed the network diagrams to determine if a network meta-analysis is feasible. Then we performed the network meta-analysis within a frequentist framework using multivariate meta-analysis estimated by restricted maximum likelihood. All analyses were done using Stata statistical software, release 15 (StataCorp, College Station, TX). We used the network suite of Stata commands designed for this purpose (White 2012; White 2015).

Assessment of statistical heterogeneity

Assumptions when estimating the heterogeneity

In pairwise meta-analyses, we estimated the heterogeneity for each comparison. In network meta-analysis we assumed a common estimate for the heterogeneity variance across all of the different comparisons.

Measures and tests for heterogeneity

We assessed statistically the presence of heterogeneity within each pairwise comparison for the primary outcomes using the I^2 statistic that measures the percentage of variability that cannot be attributed to random error (Higgins 2002). The certainty of the evidence was downgraded for inconsistency where $I^2 \geq 60\%$. The assessment of statistical heterogeneity in the entire network was based on the magnitude of the heterogeneity variance parameter estimated from the multivariate meta-analysis.

Assessment of statistical inconsistency

To check the assumption of consistency in the entire network we used the "design-by- treatment" interaction model as described by Higgins (Higgins 2012). This method accounts for a different source of inconsistency that can occur when studies with different designs (two-arm trials versus three-arm trials) give different results as well as disagreement between direct and indirect evidence. Using this approach we inferred about the presence of inconsistency from any source in the entire network based on a Chi^2 test.

Investigation of heterogeneity and inconsistency

Where we found important heterogeneity and/or inconsistency, we explored the possible sources for primary outcomes. Where sufficient studies were available, we performed multivariate meta-analyses for subgroups and sensitivity analyses by using potential effect modifiers as possible sources of inconsistency and/or heterogeneity.

Subgroup analysis

For the primary outcomes we carried out the following pre-specified subgroup analyses.

1. Population: prior risk of PPH (high versus low), mode of delivery (vaginal versus caesarean birth), setting (hospital versus community).
2. Intervention: dose of misoprostol (≥ 600 mcg versus < 600 mcg), and regimen of oxytocin (bolus versus bolus plus infusion versus infusion only).

We assessed subgroup differences by firstly comparing the network diagram for each subgroup. Next, we performed a pairwise and network meta-analysis for each subgroup and we compared their relative treatment effects and their relative treatment ranking. We examined the subgroups for qualitative interactions where the direction of effect could be reversed, that is if an intervention was beneficial in one subgroup but harmful in another.

Sensitivity analysis

For the primary outcomes we performed sensitivity analysis for the following.

1. Risk of bias (restricted to low risk of bias studies only): studies are ranked as 'low risk of bias' if they are double-blinded, and have allocation concealment with little loss to follow-up (less than 10%). The concealed studies with assessor blinding and little loss to follow-up (less than 10%) are ranked as 'intermediate risk of bias' and the rest as 'high risk of bias'. We considered that assessor blinding was likely to be very important, in order to eliminate any risk of bias in subjective measurements or estimates of blood loss (not all studies measure this outcome objectively). We considered protocol publication in advance of the results to be an unsuitable criterion for sensitivity analyses, because protocol publication only became widespread in recent years.
2. Funding source (restricted to studies with funding source at low risk of bias (public or no funding)).
3. Whether an objective method of outcome assessment was employed (restricted to studies with an objective method of measuring blood loss). Objective methods of blood loss measurement were considered to be all methods that employed a measurement of the blood loss. This is in contrast to subjective methods where a healthcare professional is estimating the blood loss, usually visually.
4. Trial size (restricted to large studies (> 400 participants), in recognition of the greater likelihood for small studies than large or multi-centre studies to suffer publication bias). In terms of trial size, there is evidence that smaller studies can exaggerate estimated benefits (Nüesch 2010). However, the cut-off for deciding the definition of a small study can vary between research topics. For this topic, it appears that trials with more than 400 participants are more likely to be of higher quality, prospectively registered and overall at low risk of bias.
5. Removing trials that also randomised participants to co-interventions such as uterine massage or controlled cord traction.
6. Removing trials with more than 10% missing data.
7. Removing trials published before 1990.
8. Randomisation unit (restricted to individually-randomised trials and removing cluster-randomised trials).
9. Choice of relative effect measure (risk ratio (RR) versus odds ratio (OR)).
10. Use of fixed-effect versus random-effects model.

Differences were assessed by evaluating the relative effects and assessment of model fit.

RESULTS

Description of studies

Results of the search

The results of the search are summarised in the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram (Figure 1).

The search of Cochrane Pregnancy and Childbirth's (CPC) Trials Register on 24 May 2018 retrieved in total 590 records. We retrieved a further 144 records from additional author searches and manual searching of reference lists for a total of 734 available records. From these, we excluded 136 records as duplicates. We examined the full text of 598 records and included in the network meta-analysis 196 randomised trials (reported in 261 publications).

We contacted the authors from 98 randomised trials for additional data or clarifications. We were able to obtain additional data from trial authors for 39 randomised trials (Characteristics of included studies and Appendix 2). We excluded 278 trials (reported in 314 publications) (Characteristics of excluded studies), 11 trials (reported in 13 publications) could not be classified (Studies awaiting classification) and 10 trials were still ongoing (Ongoing studies).

Included studies

The network meta-analysis includes 196 randomised trials involving 135,559 women. Most studies were reported in English; 11 translations were obtained (six Spanish, two French, two Turkish and one Chinese). The studies were conducted across 53 countries

(including high-, middle- and low-income countries) and often involved more than one country. A number of multi-arm trials were identified: two five-arm trials, eight four-arm trials and 22 three-arm trials. The median size of the trials was around 213 participants (interquartile range (IQR) 123 to 529).

Most trials (95.4%, 187/196) were performed in a hospital setting, seven were performed in a community setting (3.6%), one (0.5%) in a mixed setting and one (0.5%) of unspecified setting. The majority of the trials included women undergoing a vaginal birth (71.5%, 140/196), and 53 trials (27%) involved women undergoing elective or emergency caesareans. Only two (1%) trials included women undergoing either a vaginal birth or caesarean and in one trial (0.5%) the mode of birth was not specified. Women included in the trials were judged to be at high risk for postpartum haemorrhage (PPH) in 66 of 196 trials (33.7%), low risk in 52 trials (26.5%) and 68 trials (34.7%) included women both at high or low risk for PPH. The risk for PPH was not specified in 10 trials (5.1%).

Women with a singleton pregnancy only were recruited in 124 trials (63.3%), 36 trials (18.4%) included women with either singleton or multiple pregnancies and only one trial (0.5%) included women with twin pregnancies only. Thirty-five trials (17.8%) did not specify. Six trials (3.1%) included only nulliparous or primigravida women, one trial included only multiparous women (0.5%), 108 trials (55.1%) included both nulliparous and multiparous women of all parities, and 81 trials (41.3%) did not specify the parity of the women included in the trials. Exclusion criteria varied significantly and usually encompassed women with significant medical comorbidities.

Across all 196 trials (412 trial arms) in the network meta-analysis, the following agents were used either as intervention or comparison:

1. 137 trial arms (33.3%) used oxytocin;
2. 96 trial arms (23.3%) used misoprostol;
3. 39 trial arms (9.5%) used ergometrine;
4. 35 trial arms (8.5%) used ergometrine plus oxytocin;
5. 33 trial arms (8%) used carbetocin;
6. 29 trial arms (7%) used placebo or no treatment;
7. 26 trial arms (6.3%) used misoprostol plus oxytocin;
8. 17 trial arms (4.1%) used injectable prostaglandins.

See Characteristics of included studies for details.

Excluded studies

We excluded 278 trials (for details *see* Characteristics of excluded studies). The most common reasons for exclusion were because trials were comparing exclusively doses or routes of the same uterotonic agents, trials that were quasi randomised or trials investigating ineligible interventions such as tranexamic acid.

Risk of bias in included studies

We present summaries of the methodological quality of the included studies for each of the domains we assessed across all studies (Figure 2) and for each included study (Figure 3).

Figure 2. 'Risk of bias' graph: review authors' judgements about each risk of bias item presented as percentages across all included studies.

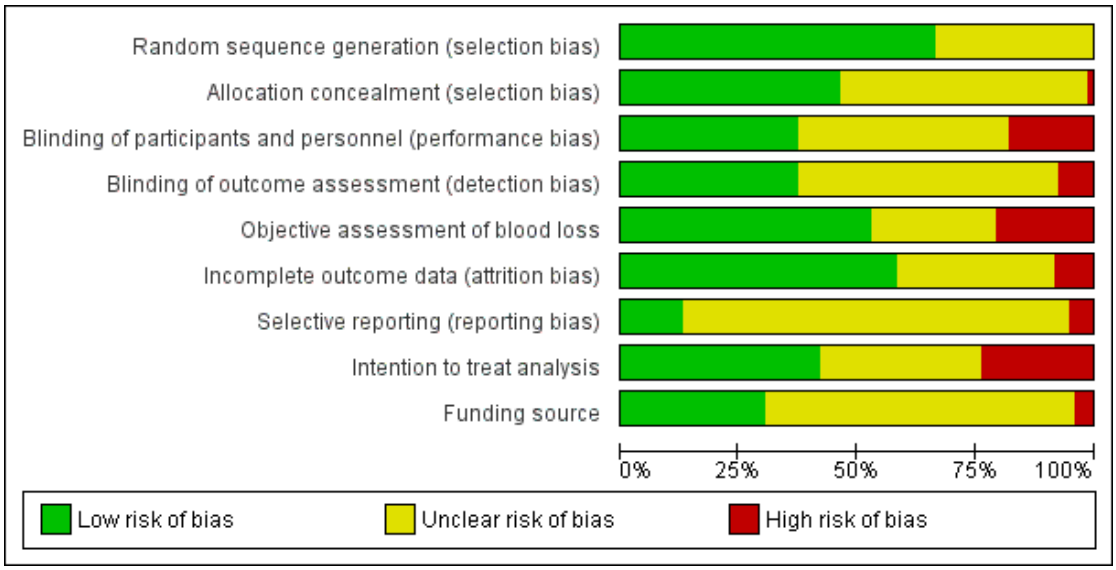


Figure 3. 'Risk of bias' summary: review authors' judgements about each risk of bias item for each included study.

Allocation

Trials with evidence of inadequate random sequence generation were excluded from this review. As a result 130 of 196 included trials (66.3%) were found to have used an adequate method generating the random sequence and were at low risk of bias. However, 66 trials (33.7%) did not report the method used in sufficient detail and the risk of bias was judged to be unclear. Ninety of 196 trials (45.9%) reported adequate methods for allocation concealment and were judged to be at low risk of bias. Only three trials (1.5%) showed evidence of inadequate allocation concealment and 103 trials (52.6%), did not provide enough information to assess allocation concealment and the risk of bias was judged to be unclear.

Blinding

In total, 73 of 196 trials (37.2%) reported adequate methods for blinding both participants and personnel to treatment allocation. Thirty-five trials (17.9%) were judged to be at high risk of bias for blinding of participants and personnel. Eighty-eight trials (44.9%) did not provide enough information to assess the blinding of participants and personnel and the risk of bias was judged to be unclear. Seventy-three of 196 trials (37.2%) reported adequate methods for blinding the assessment of the primary outcomes. Fifteen trials (7.7%) were judged to be at high risk of bias for blinding the assessment of the primary outcomes. There were 108 trials (55.1%) that did not provide enough information for blinding the assessment of the primary outcomes and the risk of bias was judged to be unclear.

Incomplete outcome data

There were 114 of 196 trials (58.1%) that were judged to be at a low risk of bias. In these trials, missing outcome data were less than 10% for the primary outcomes of the review and balanced in numbers across intervention groups with similar reasons for missing data across groups. In 16 trials (8.2%), more than 10% of patients dropped out or were not analysed as per the "intention-to-treat" principles following randomisation, indicating a high risk of bias. Sixty-six trials (33.7%) did not provide enough information to assess so that it was uncertain whether or not the handling of incomplete data was appropriate and the risk of bias was judged to be unclear in these trials.

Selective reporting

Only 25 of 196 trials (12.8%) pre-specified all outcomes in publicly available study protocols and were judged to be at low risk of bias. Ten trials (5.1%) did not report all pre-specified outcomes as reported in their published protocols or methodology within the main report and were judged to be at high risk of bias for selective reporting. For most trials (161 trials; 82.1%), we were unable to identify a published protocol and the risk of bias was judged to be unclear.

Other potential sources of bias

Eighty-two of 196 trials (41.8%) analysed data by the intention-to-treat principle and were judged to be at low risk of bias. Forty-seven trials (24%) did not analyse data by the intention-to-treat principle and were judged to be at high risk of bias. For 67 trials (34.2%), we were unable to identify whether data were analysed by the intention-to-treat principle and the risk of bias was judged to be unclear.

We found that 59 of 196 trials (30.1%) were either conducted with public or no funding, and declared that they had no potential conflicts of interest. Eight trials (4.1%) were judged to be at high risk of bias as they were funded directly by the manufacturer of the drug under investigation. There were 129 trials (65.8%) that did not provide enough information to assess the source of funding or potential conflicts of interest and the risk of bias was judged to be unclear.

Among all the studies, 103 of 196 trials (52.6%) reported relatively objective methods for measuring blood loss such as weighing sponges, measurements in drapes or volumetric assessment and were judged to be at low risk of bias. The studies that did not measure blood loss as this was not an outcome of interest were also considered at low risk of bias. Forty-one trials (20.9%) were judged to be at high risk of bias for measuring blood loss as they used subjective measurement such as clinical or visual estimates. Fifty-two trials (26.5%) did not provide enough information to assess the method for measuring blood loss, and the risk of bias was judged to be unclear.

For the purpose of sensitivity analysis we analysed how many trials were judged to be at low, intermediate or high overall risk of bias. For PPH $\geq$ 500 mL, 38 of 124 trials (30.6%) were found to be at low overall risk of bias. Eighty-six of 124 trials (69.4%) were judged to be at high risk of bias as they were judged to be either at high risk or unclear risk of bias for at least one of the domains mentioned above. There were no trials judged as intermediate risk of bias - see Sensitivity analysis for information about how this risk of bias has impacted the results.

Effects of interventions

See: **Summary of findings for the main comparison** PPH >= 500 mL; **Summary of findings 2** PPH >= 1000 mL; **Summary of findings 3** Additional uterotonics; **Summary of findings 4** Blood transfusion; **Summary of findings 5** Vomiting; **Summary of findings 6** Hypertension; **Summary of findings 7** Fever

Please note that all of the analyses presented in the Data and analyses section relate to the 'direct evidence' and were used as per our methods to grade the evidence. The results from Data and analyses were also used to check the direction of effect in the subgroups and not to formally check for subgroup effects using the interaction test. These results are not described.

The following section presents the results as reported in all of the figures (Figure 4 to Figure 5). The figures present the results from the network diagrams, the forest plots with the pairwise, indirect and network (combining direct and indirect) effect estimates and the cumulative rankograms for all the outcomes with available data. The figures present the results for different uterotonics in comparison to placebo or no treatment and different uterotonics in comparison to the reference uterotonic agent oxytocin. All other comparisons are available from Appendix 2.

Figure 4. Network Diagram for PPH ≥ 500 mL. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

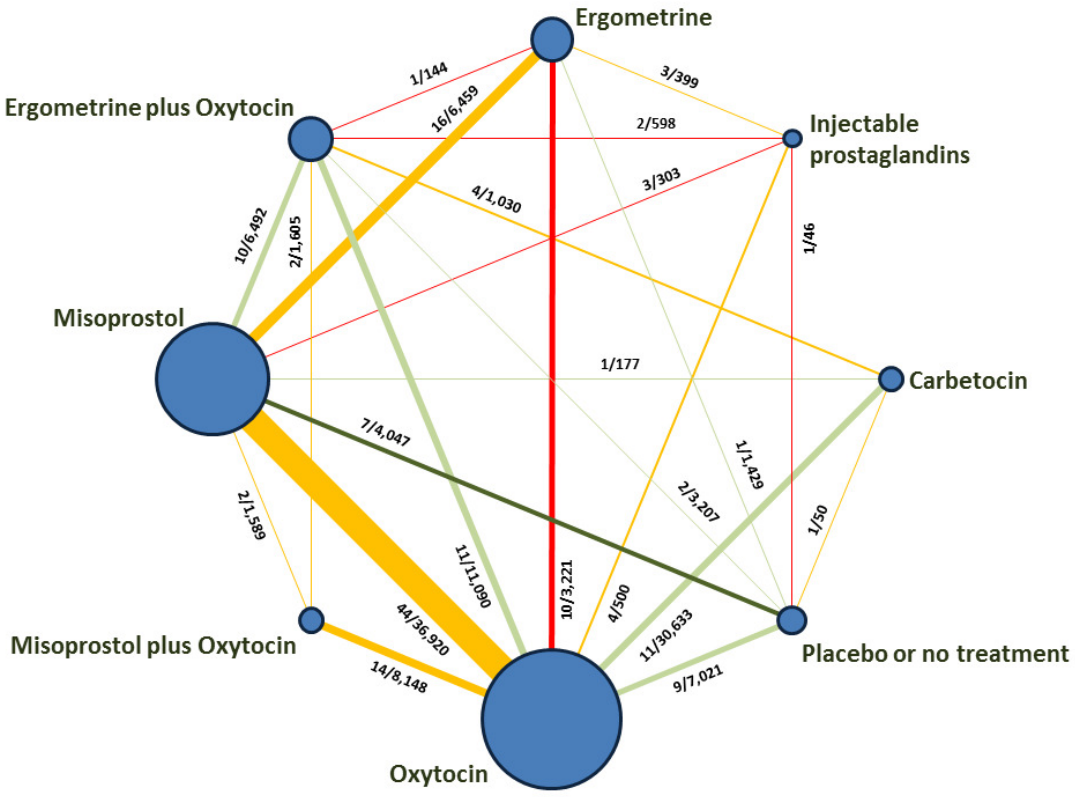
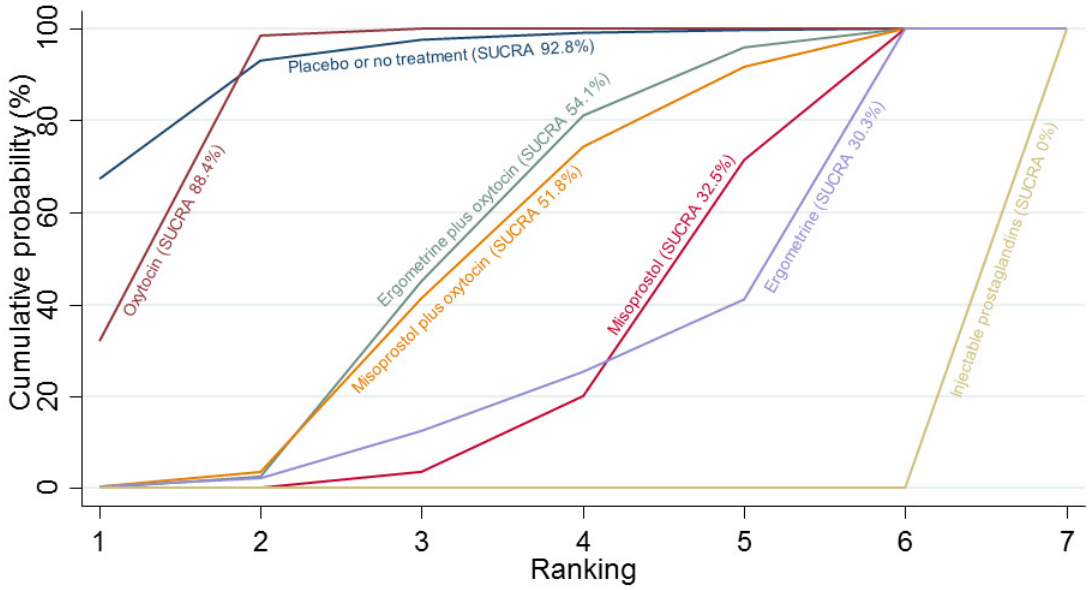


Figure 5. Cumulative rankograms comparing each of the uterotonic agents for diarrhoea. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SURface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



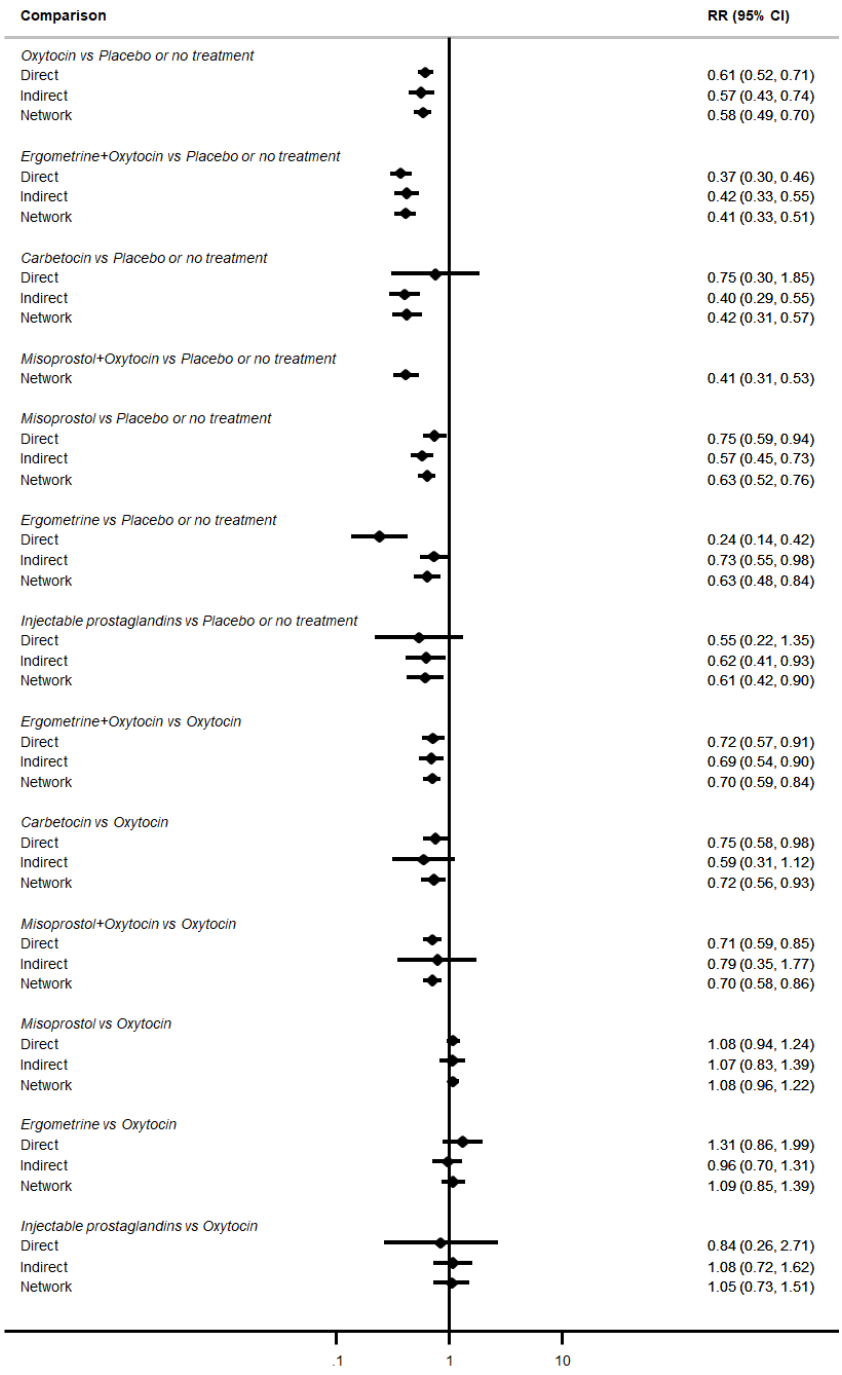
Primary outcomes

Postpartum haemorrhage (PPH) ≥ 500 mL

The network diagram for PPH ≥ 500 mL is presented in Figure 4. Oxytocin was the most frequently investigated uterotonic agent (88 of 124 trials, 71%) for this outcome (Figure 4).

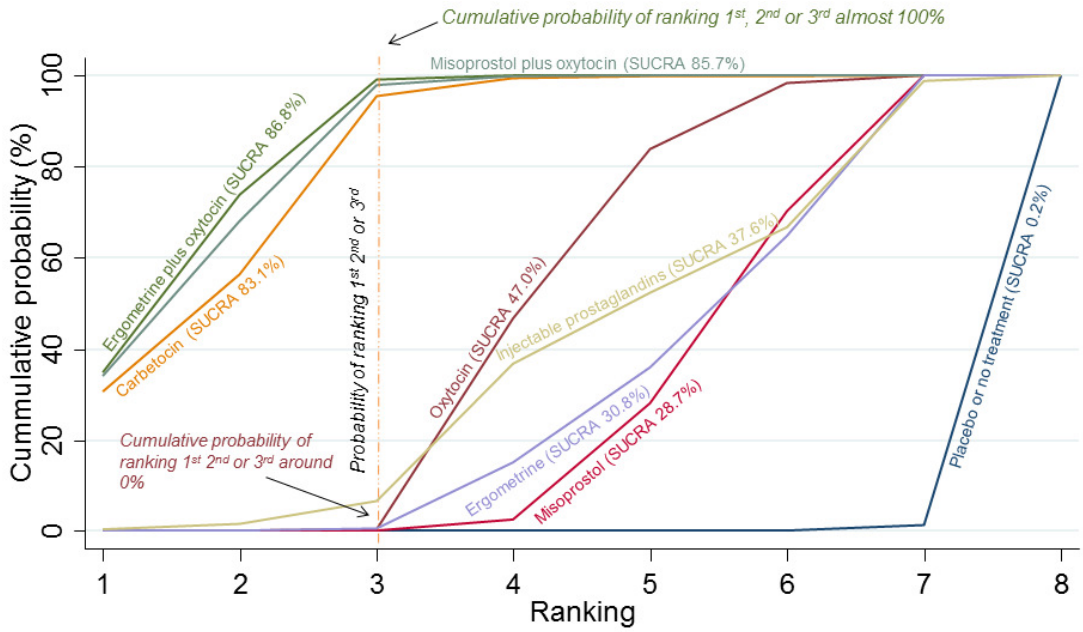
Relative effects from the network meta-analysis of 124 trials suggested that all agents were effective for preventing PPH ≥ 500 mL when compared with placebo or no treatment (Figure 6). When compared with oxytocin, ergometrine plus oxytocin combination, carbetocin, and misoprostol plus oxytocin combination were more effective in preventing PPH ≥ 500 mL. When compared with oxytocin, moderate-certainty evidence suggests that carbetocin (risk ratio (RR) 0.72, 95% confidence interval (CI) 0.56 to 0.93) and ergometrine plus oxytocin (RR 0.70, 95% CI 0.59 to 0.84) probably reduce PPH ≥ 500 mL, while low-certainty evidence suggests that misoprostol plus oxytocin (RR 0.70, 95% CI 0.58 to 0.86) may reduce PPH ≥ 500 mL. Low-certainty evidence suggests that misoprostol, injectable prostaglandins, and ergometrine may make little or no difference to this outcome compared with oxytocin (Summary of findings for the main comparison). Based on these results, about 122 per 1000 women given oxytocin for a vaginal birth would experience a PPH of ≥ 500 mL compared with 85 given ergometrine plus oxytocin combination, 87 given carbetocin, and 85 given misoprostol plus oxytocin (Summary of findings for the main comparison).

Figure 6. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for prevention of PPH ≥ 500 mL.



The cumulative probabilities for each agent being at each possible rank for preventing PPH ≥ 500 mL are shown in Figure 7. Treatment hierarchies are presented with the surface under the cumulative ranking curve (SUCRA); the larger the SUCRA the higher its rank among all available agents. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. A SUCRA of 100% means the uterotonic agent is the best and a SUCRA of 0% means the agent is the worst. The highest ranked agents were ergometrine plus oxytocin combination (SUCRA 86.8%), misoprostol plus oxytocin combination (SUCRA 85.7%) and carbetocin (SUCRA 83.1%). Oxytocin ranked fourth (47%) followed by injectable prostaglandins (SUCRA 37.6%), ergometrine (SUCRA 30.8%), misoprostol (SUCRA 28.7%) and placebo or no treatment (SUCRA 0.2%).

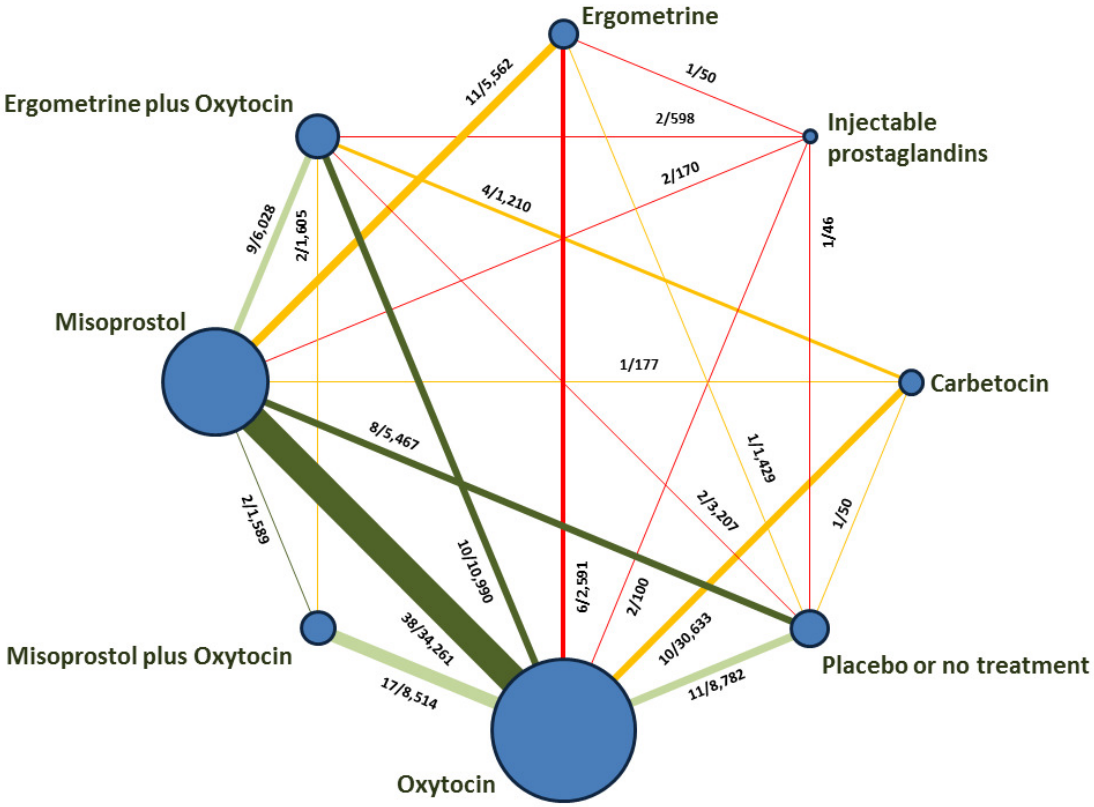
Figure 7. Cumulative rankograms comparing each of the uterotonic agents for prevention of PPH ≥ 500 mL. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Postpartum haemorrhage (PPH) ≥ 1000 mL

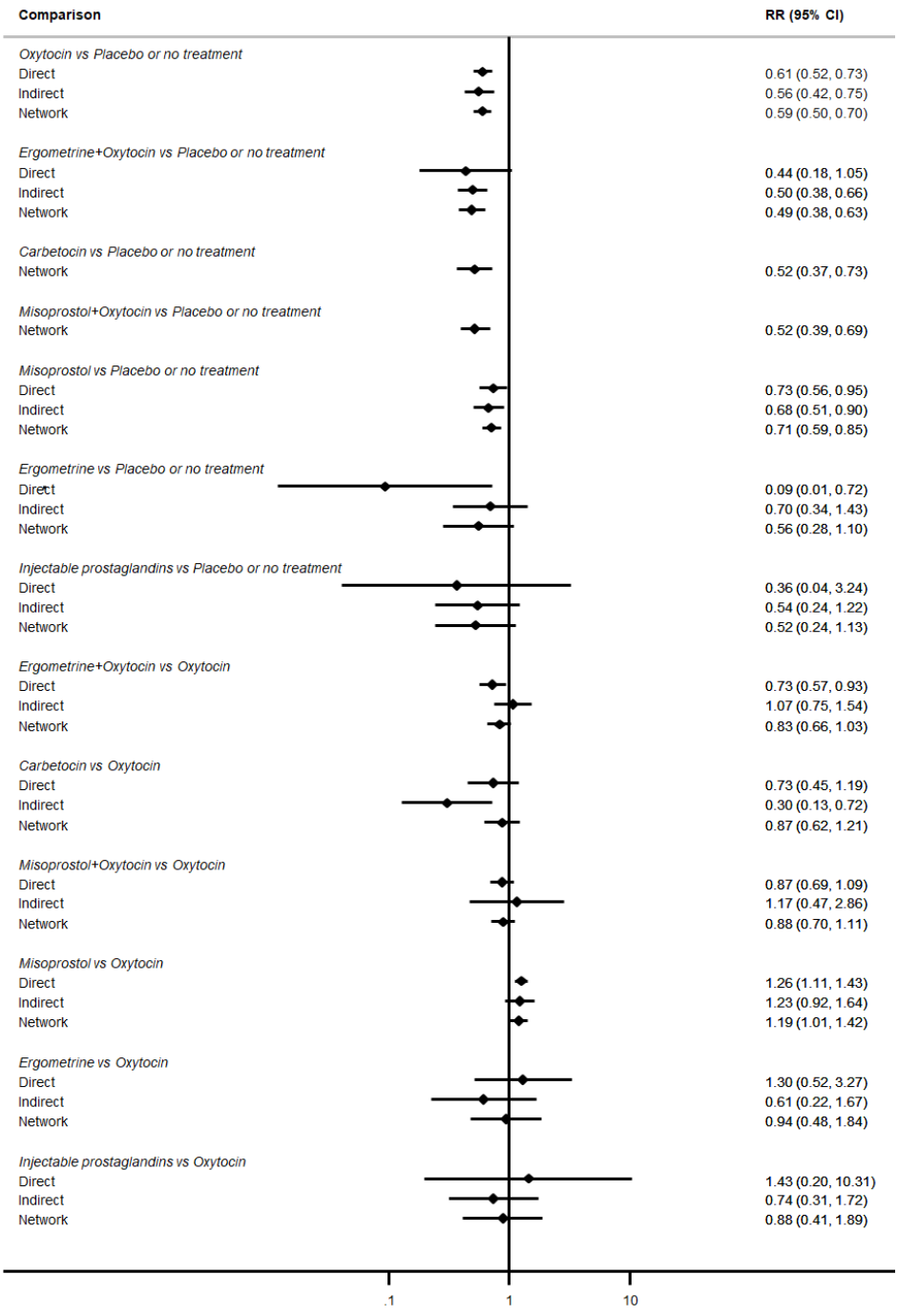
The network diagram for PPH ≥ 1000 mL is presented in Figure 8. Oxytocin was the most frequently investigated uterotonic agent (72.7%, 80 of 110 trials) for this outcome (Figure 8).

Figure 8. Network Diagram for PPH ≥ 1000 mL. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.



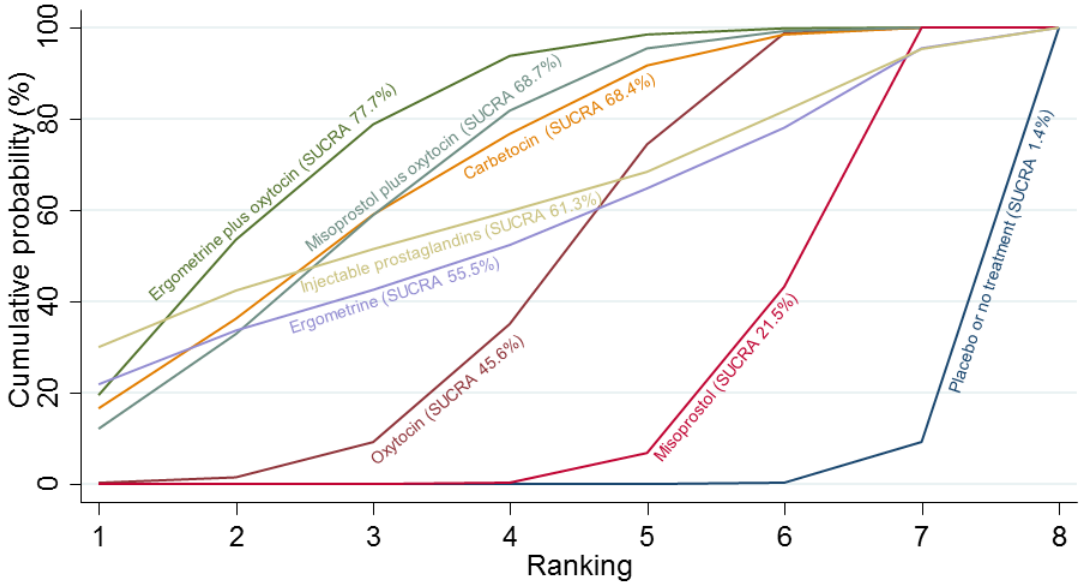
Relative effects from the network meta-analysis of 110 trials suggested that all agents except ergometrine and injectable prostaglandins were effective for preventing PPH ≥ 1000 mL when compared with placebo or no treatment (Figure 9). No differences were observed in the effects of uterotonic agents compared with the reference uterotonic agent oxytocin for PPH ≥ 1000 mL. High-certainty evidence suggests that misoprostol plus oxytocin (RR 0.88, 95% CI 0.70 to 1.11) and ergometrine plus oxytocin (RR 0.83, 95% CI 0.66 to 1.03) make little or no difference to PPH ≥ 1000 mL when compared with oxytocin. In absolute terms, these results suggest that about 30 per 1000 women given oxytocin for a vaginal birth would experience PPH ≥ 1000 mL, compared with 26 given misoprostol plus oxytocin and 25 given ergometrine plus oxytocin. Low-certainty evidence suggests that ergometrine (RR 0.94, 95% CI 0.48 to 1.84) may make little or no difference to this outcome when compared with oxytocin. The evidence for carbetocin and injectable prostaglandins was uncertain. High-certainty evidence suggests that misoprostol is less protective against PPH ≥ 1000 mL when compared with oxytocin (RR 1.19, 95% CI 1.01 to 1.42) (Summary of findings 2).

Figure 9. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for prevention of PPH ≥ 1000 mL.



Despite the comparable relative treatment effects between all uterotonics (except misoprostol) and oxytocin, cumulative probabilities for each agent being at each possible rank for PPH ≥ 1000 mL are shown in Figure 10. Ergometrine plus oxytocin (SUCRA 77.7%), misoprostol plus oxytocin (SUCRA 68.7%) combinations and carbetocin (SUCRA 68.4%) were the highest ranked agents. Oxytocin ranked sixth (45.6%) after injectable prostaglandins (SUCRA 61.3%) and ergometrine (SUCRA 55.5%). Misoprostol was seventh (SUCRA 21.5%) ranking higher than placebo or no treatment (1.4%).

Figure 10. Cumulative rankograms comparing each of the uterotonic agents for prevention of PPH ≥ 1000 mL. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SURface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Secondary outcomes

Maternal death

The network diagram for maternal death is presented in Figure 11. Relative effects from the network meta-analysis of 59 trials suggested that no meaningful differences could be detected between all uterotonic agents for maternal deaths as this outcome was rare (14 deaths across all trials were reported) (Figure 12). When compared with oxytocin, carbetocin (RR 2.00, 95% CI 0.37 to 10.92) and misoprostol (RR 0.62, 95% CI 0.14 to 2.74) probably make little or no difference to maternal death. Network relative effects were not estimable for the comparisons of other uterotonics with oxytocin (Figure 12).

Figure 11. Network Diagram for maternal death. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

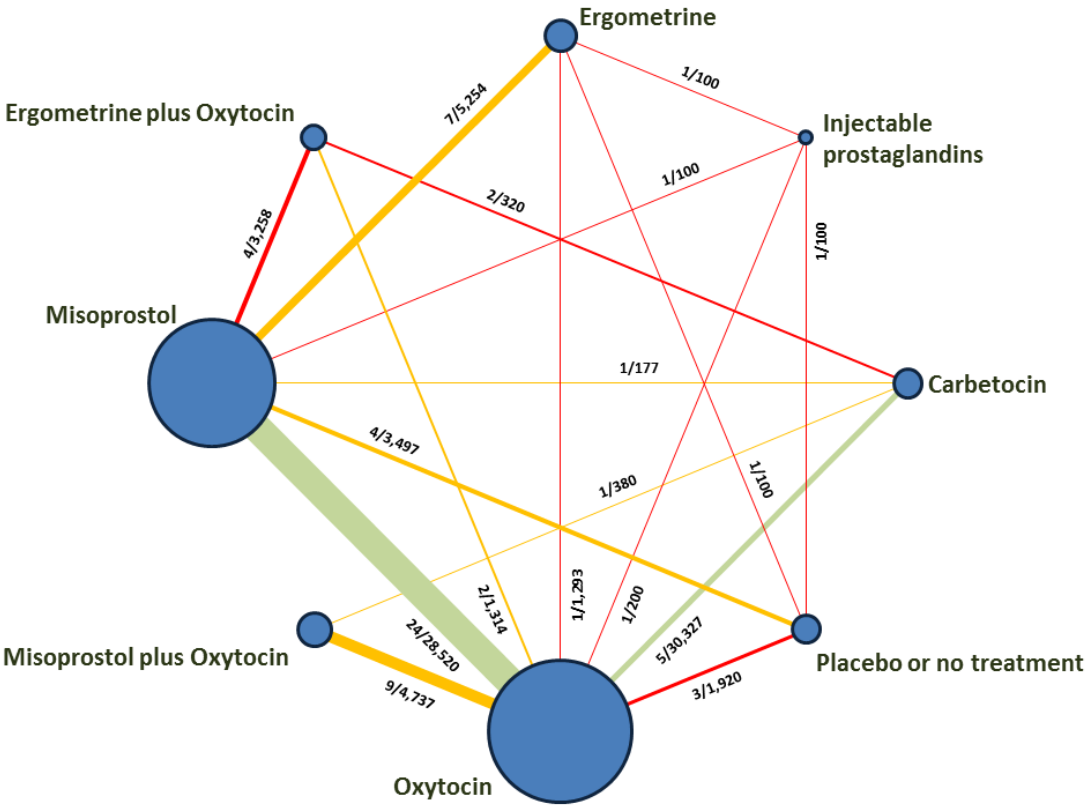


Figure 12. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for prevention of maternal death.

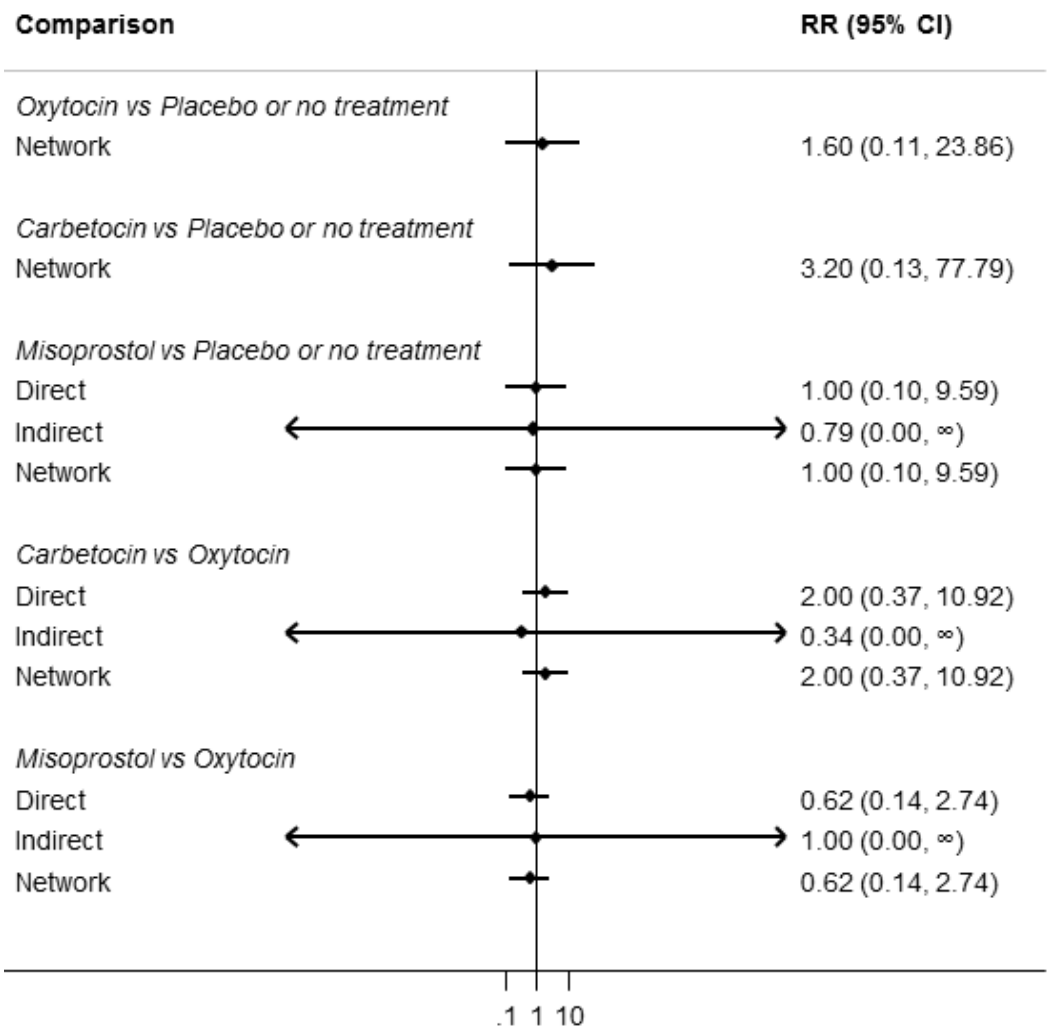
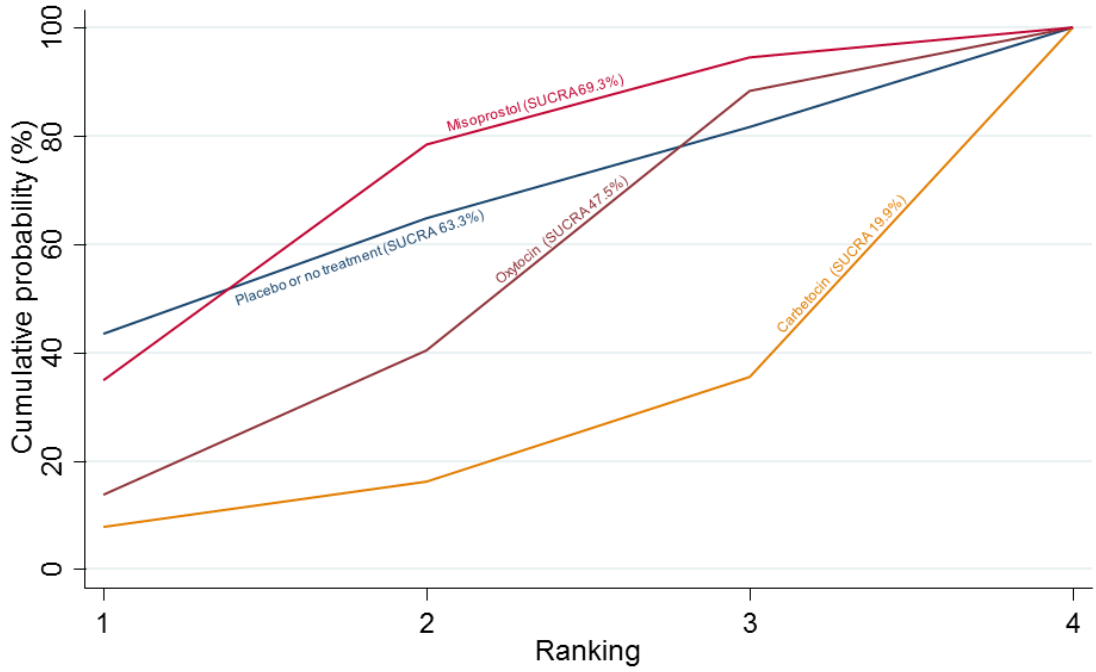


Figure 13 shows the cumulative probabilities for each agent being at each possible rank for maternal death. No reliable ranking could be derived for this outcome because of the rarity of maternal deaths.

Figure 13. Cumulative rankograms comparing each of the uterotonic agents for prevention of maternal death. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SURface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Severe maternal morbidity: intensive care admissions

The network diagram for intensive care admissions as an outcome of severe morbidity is presented in Figure 14. Relative effects from the network meta-analysis of 21 trials for the various comparisons suggested that there were no detectable differences among uterotonic agents for intensive care admissions as this outcome was rare. This outcome was not reported for any trial involving injectable prostaglandins (Figure 15).

Figure 14. Network Diagram for severe maternal morbidity: intensive care admissions. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

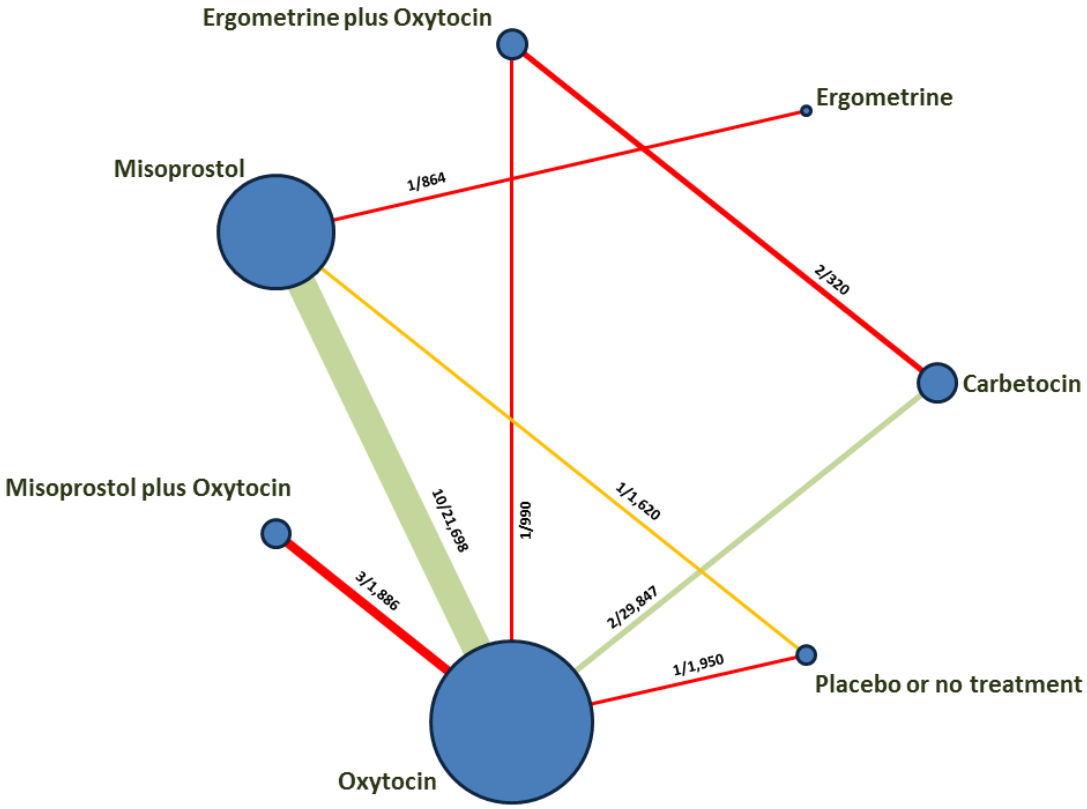


Figure 15. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for prevention of severe maternal morbidity: intensive care admissions.

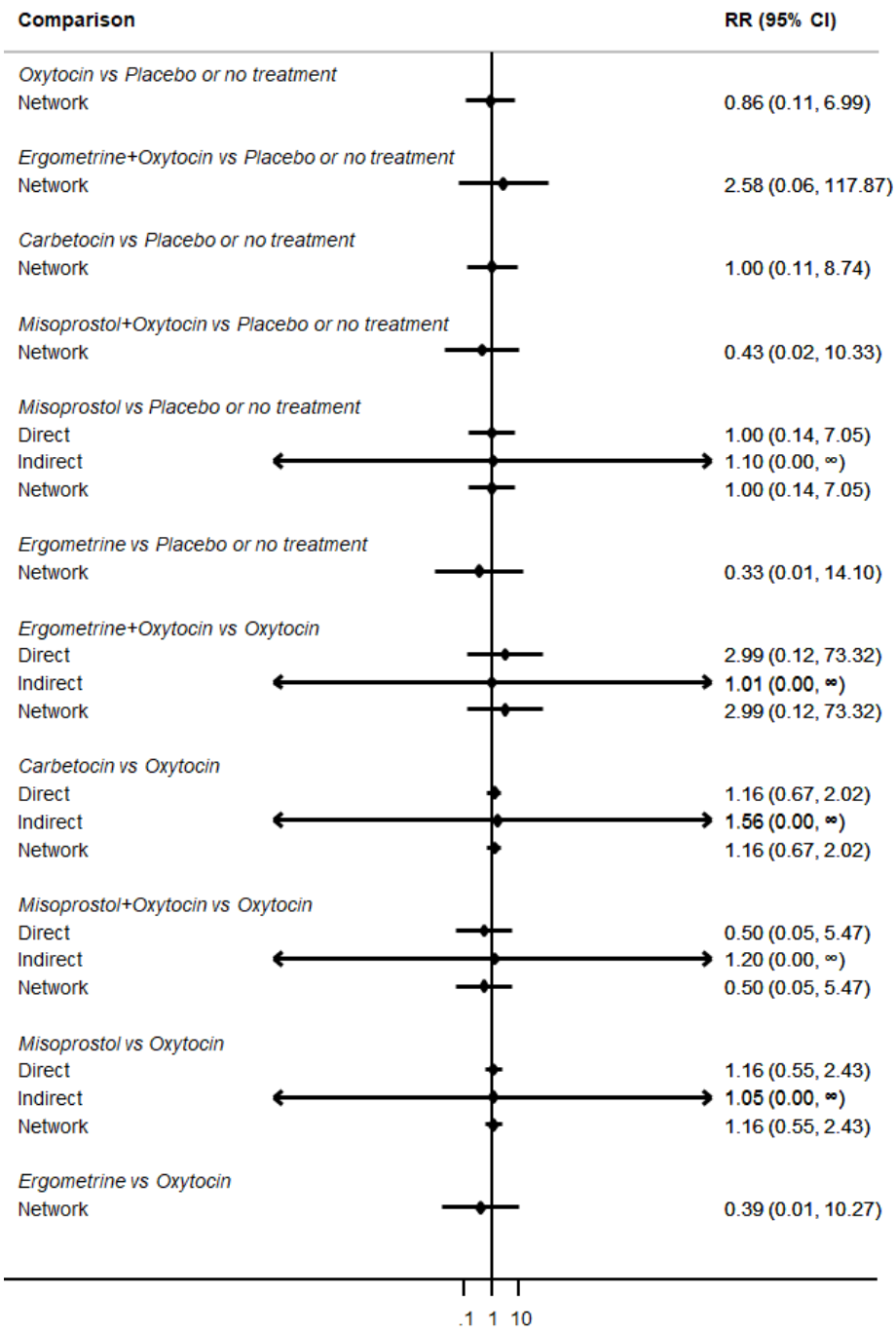
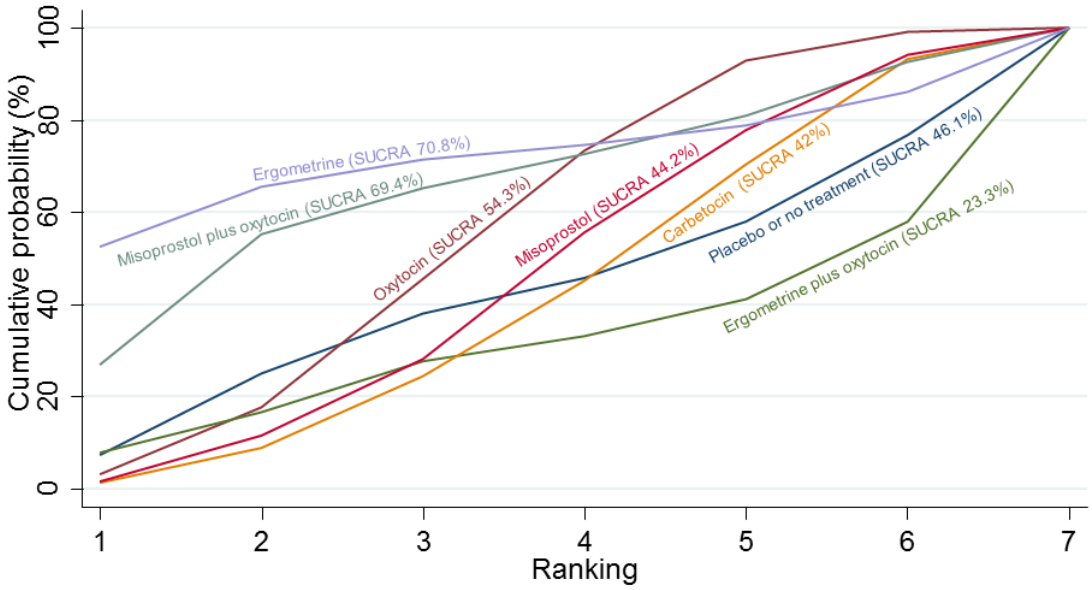


Figure 16 shows the cumulative probabilities for each agent being at each possible rank for intensive care admissions. The ranking for all agents was not clear for this outcome due to limited data.

Figure 16. Cumulative rankograms comparing each of the uterotonic agents for prevention of severe maternal morbidity: intensive care admissions. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking. We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Severe maternal morbidity: shock

There were no trials reporting shock as an outcome of severe maternal morbidity.

Additional uterotonics

The network diagram for the use of additional uterotonics is presented in Figure 17. Relative effects from the network meta-analysis of 142 trials suggested that all agents were effective at reducing the use of additional uterotonics when compared with placebo or no treatment (Figure 18). High-certainty evidence suggests that misoprostol plus oxytocin (RR 0.56, 95% CI 0.42 to 0.73) reduces the use of additional uterotonics when compared with oxytocin (Summary of findings 3). Based on these results, about 116 per 1000 women given oxytocin for a vaginal birth would require the administration of additional uterotonic agents, compared with 66 given misoprostol plus oxytocin. There is low-certainty evidence that carbetocin (RR 0.45, 95% CI 0.34 to 0.59), injectable prostaglandins (RR 0.55, 95% CI 0.31 to 0.96) and ergometrine plus oxytocin (RR 0.65, 95% CI 0.50 to 0.85) may also reduce the use of additional uterotonics compared with oxytocin. It is uncertain whether ergometrine reduces use of additional uterotonics because the certainty of this evidence is very low (Summary of findings 3).

Figure 17. Network Diagram for additional uterotonics. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

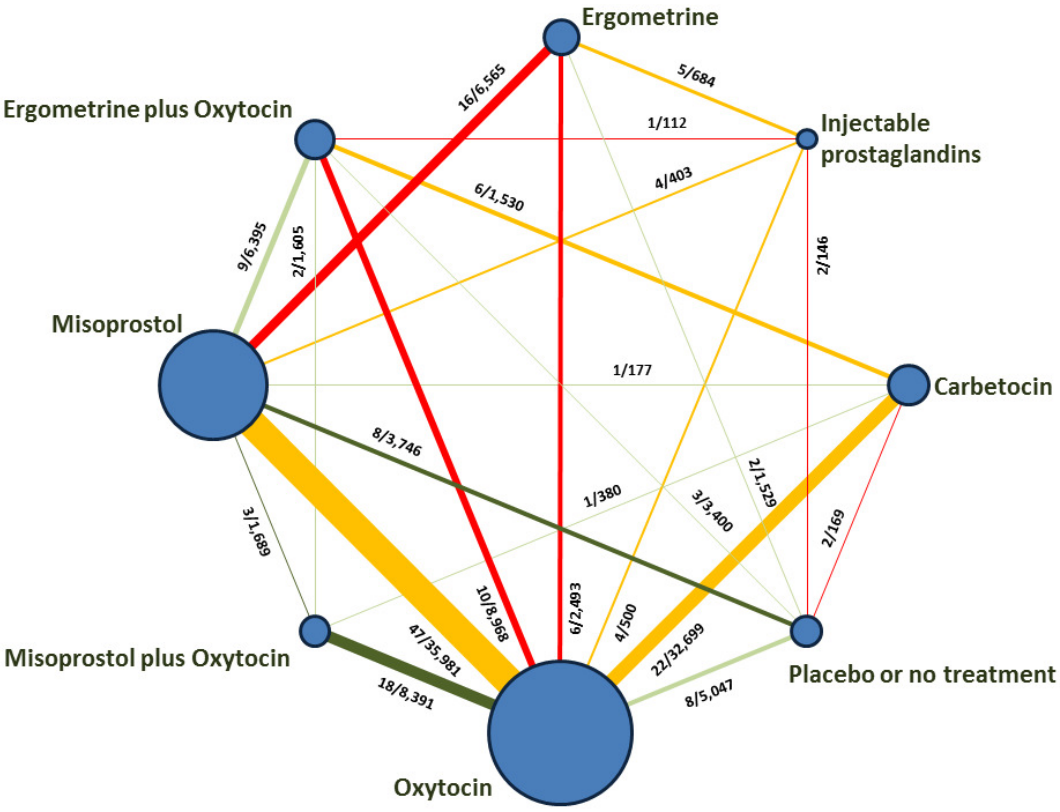


Figure 18. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for additional uterotonics.

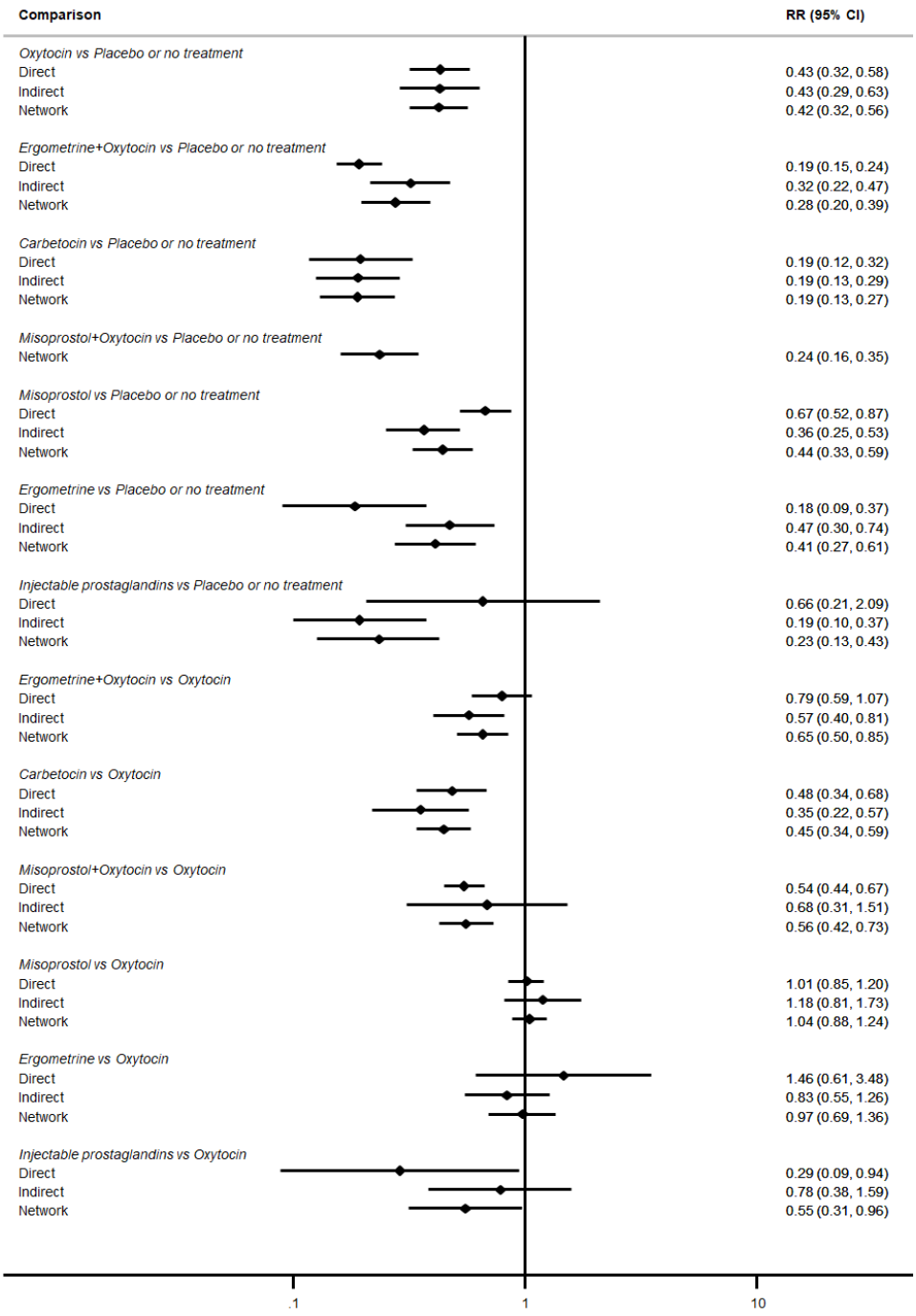
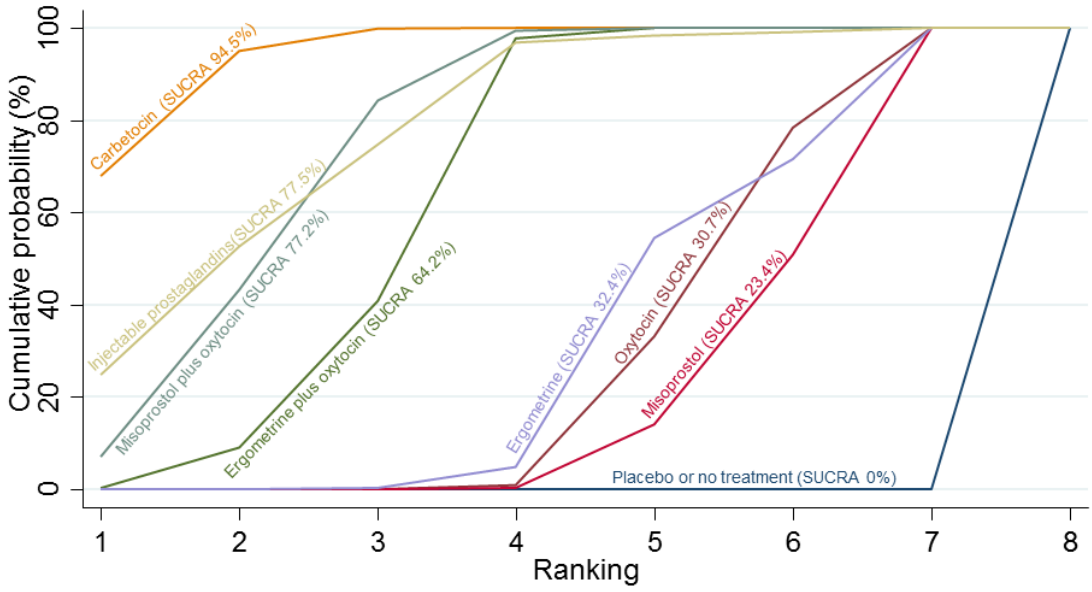


Figure 19 shows the cumulative probabilities for each agent being at each possible rank for the use of additional uterotonics. The highest ranked agents were carbetocin (SUCRA 94.5%), injectable prostaglandins (77.5%), misoprostol plus oxytocin (SUCRA 77.2%) and ergometrine plus oxytocin (SUCRA 64.2%). Oxytocin was ranked sixth (SUCRA 30.7%) behind ergometrine (SUCRA 32.4%). The lowest ranked agents were misoprostol (SUCRA 23.4%), and placebo or no treatment (SUCRA 0%).

Figure 19. Cumulative rankograms comparing each of the uterotonic agents for additional uterotonics. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Blood transfusion

The network diagram for blood transfusion is presented in Figure 20. Relative effects from the network meta-analysis of 124 trials suggested that all agents except ergometrine and injectable prostaglandins were effective for preventing blood transfusion when compared with placebo or no treatment (Figure 21). Moderate-certainty evidence suggests that misoprostol plus oxytocin probably prevents the need for blood transfusion when compared with oxytocin (RR 0.51, 95% CI 0.37 to 0.70). This suggests that whilst around 15 per 1000 women would require a blood transfusion when given oxytocin for a vaginal birth, about 8 per 1000 women would need a transfusion with misoprostol plus oxytocin. Moderate-certainty evidence suggests that carbetocin (RR 0.81, 95% CI 0.49 to 1.32) and misoprostol (RR 0.88, 95% CI 0.68 to 1.13) make little or no difference to the need for blood transfusion when compared with oxytocin. Low-certainty evidence suggests that ergometrine (RR 1.11, 95% CI 0.54 to 2.28) and ergometrine plus oxytocin (RR 0.77, 95% CI 0.58 to 1.03) may make little or no difference to this outcome when compared with oxytocin. The

evidence for injectable prostaglandins is uncertain (Summary of findings 4).

Figure 20. Network Diagram for blood transfusion. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

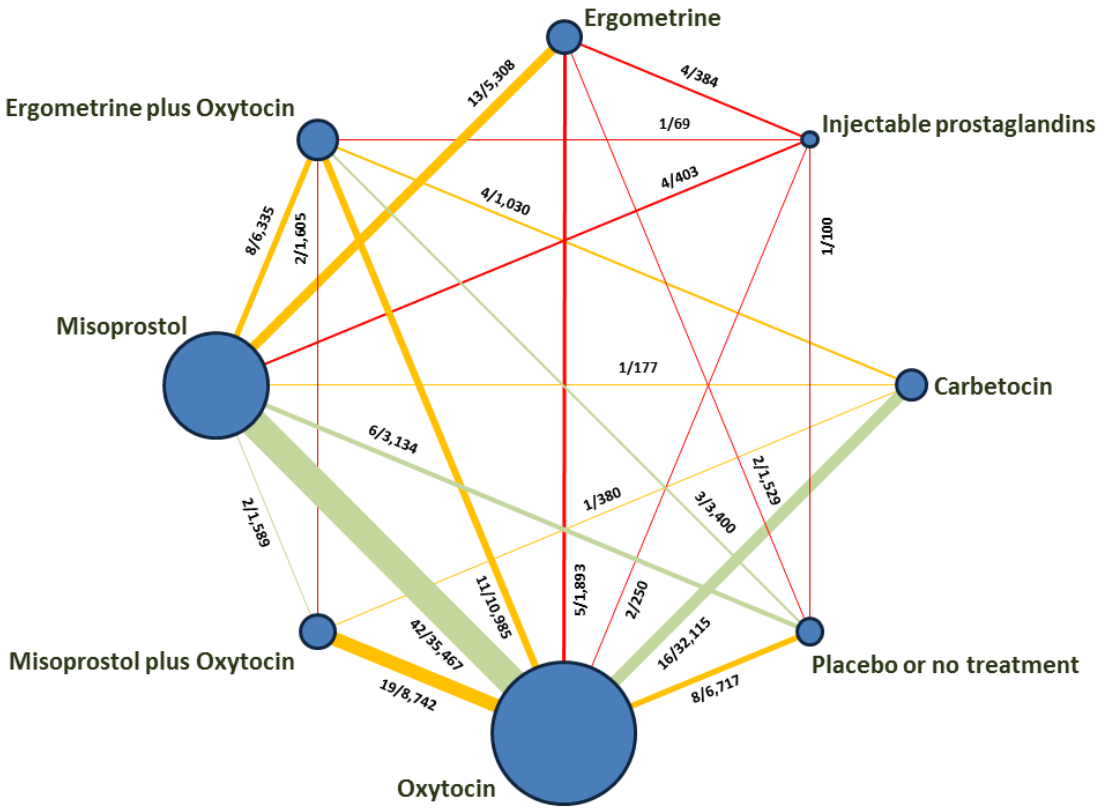


Figure 21. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for blood transfusion.

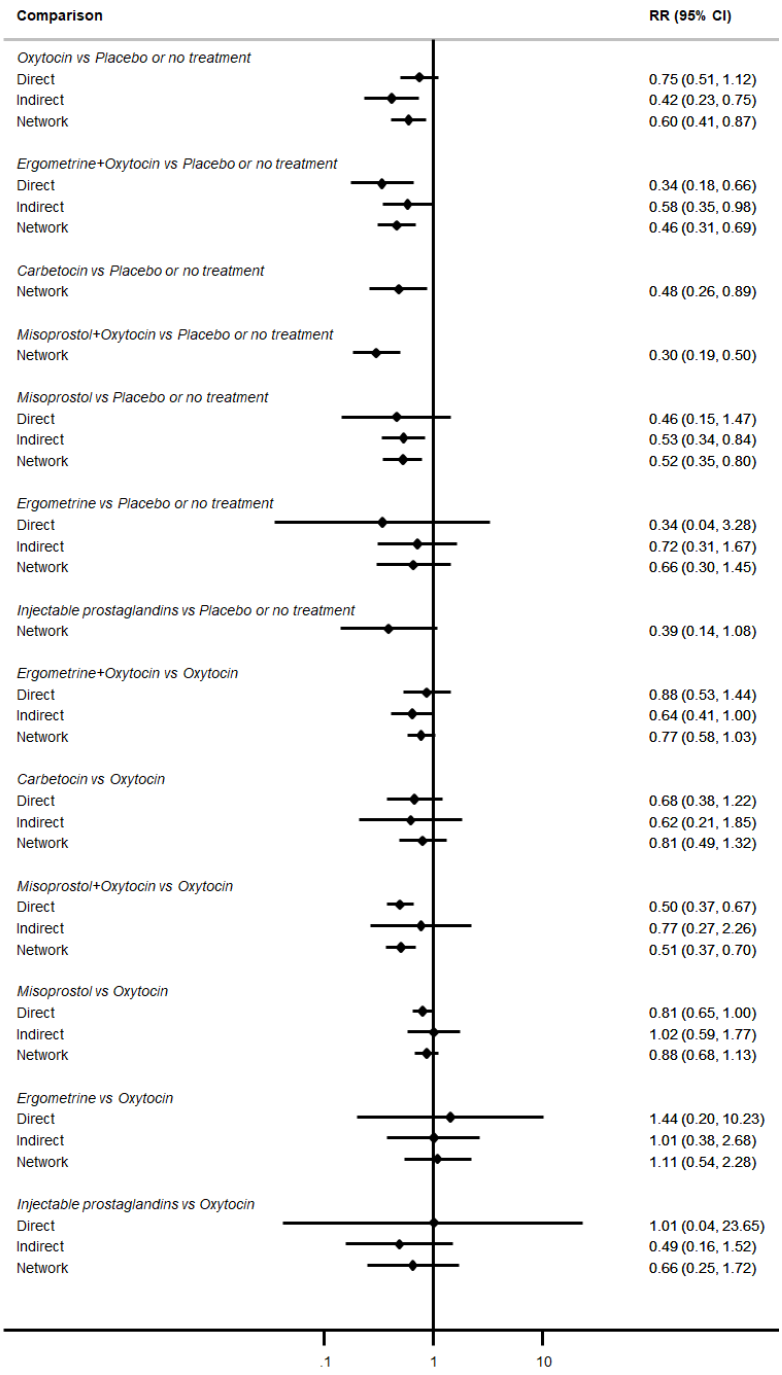
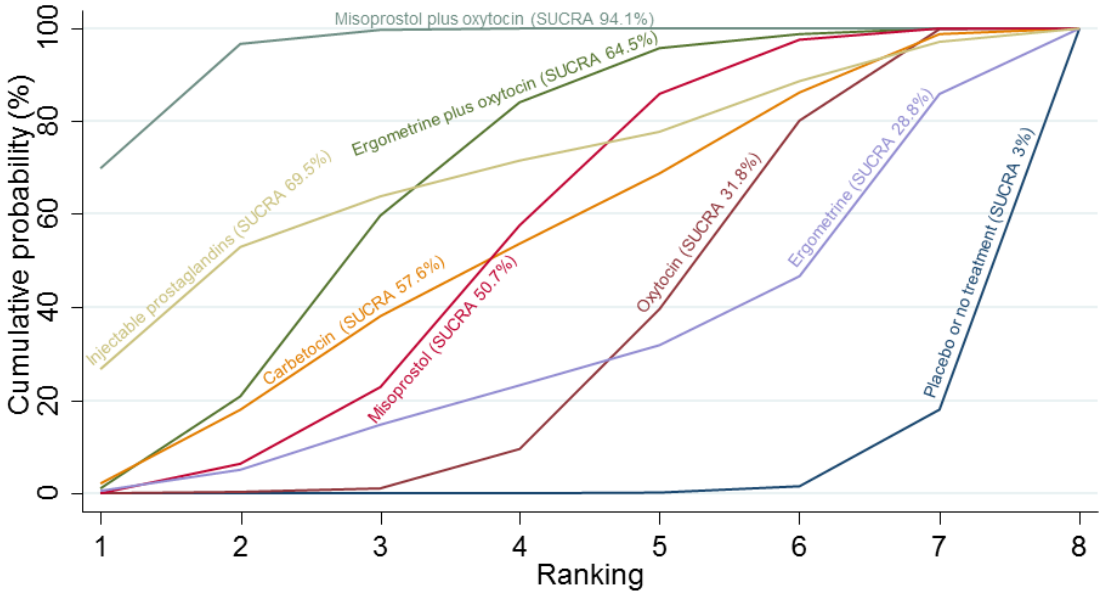


Figure 22 shows the cumulative probabilities for each agent being at each possible rank for preventing blood transfusion. The highest ranked agents were misoprostol plus oxytocin (SUCRA 94.1%), injectable prostaglandins (SUCRA 69.5%) and ergometrine plus oxytocin (SUCRA 64.5%). Oxytocin was ranked sixth (SUCRA 31.8%) behind carbetocin (SUCRA 57.6%) and misoprostol (SUCRA 50.7%), but higher than ergometrine (SUCRA 28.8%) and placebo or no treatment (SUCRA 3%).

Figure 22. Cumulative rankograms comparing each of the uterotonic agents for blood transfusion. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Mean volumes of blood loss

The network diagram for blood loss (mL) as a continuous outcome is presented in Figure 23. Relative effects from the network meta-analysis of 136 trials suggested that all agents are effective for reducing blood loss as a continuous outcome when compared with placebo or no treatment (Figure 24). When compared with oxytocin, moderate-certainty evidence suggests that blood loss is probably on average reduced among women receiving misoprostol plus oxytocin (mean difference (MD) 88.31 mL lower, 95% CI 127.08 mL lower to 49.54 mL lower), and low-certainty evidence suggests that it may be reduced among women receiving carbetocin (MD 81.39 mL lower, 95% CI 119.91mL lower to 42.87 mL lower). Low-certainty evidence suggests that there may be little or no difference between ergometrine (MD 4.82 mL higher, 95% CI 28.00 mL lower to 37.64 mL higher) and oxytocin for this outcome. The effects of misoprostol, injectable prostaglandins and ergometrine plus oxytocin were unclear because the certainty of the evidence was very low (Figure 24).

Figure 23. Network Diagram for mean blood loss (mL). The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

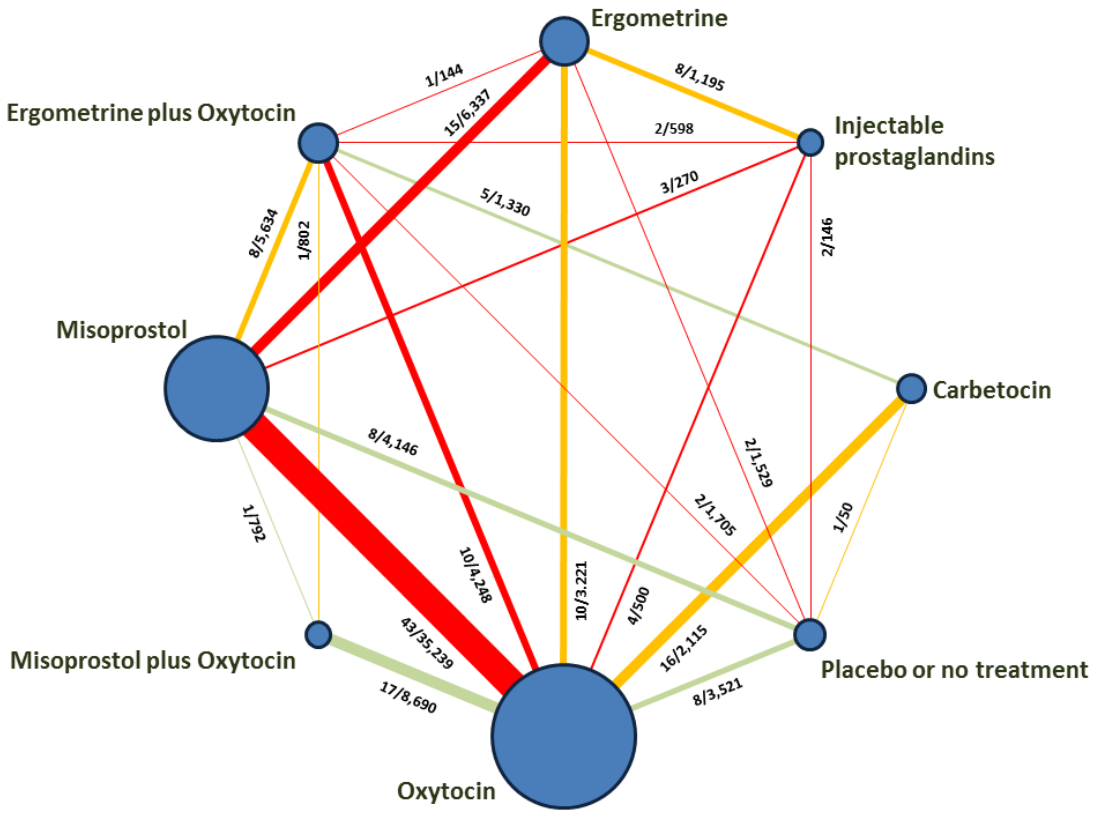


Figure 24. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for mean blood loss (mL).

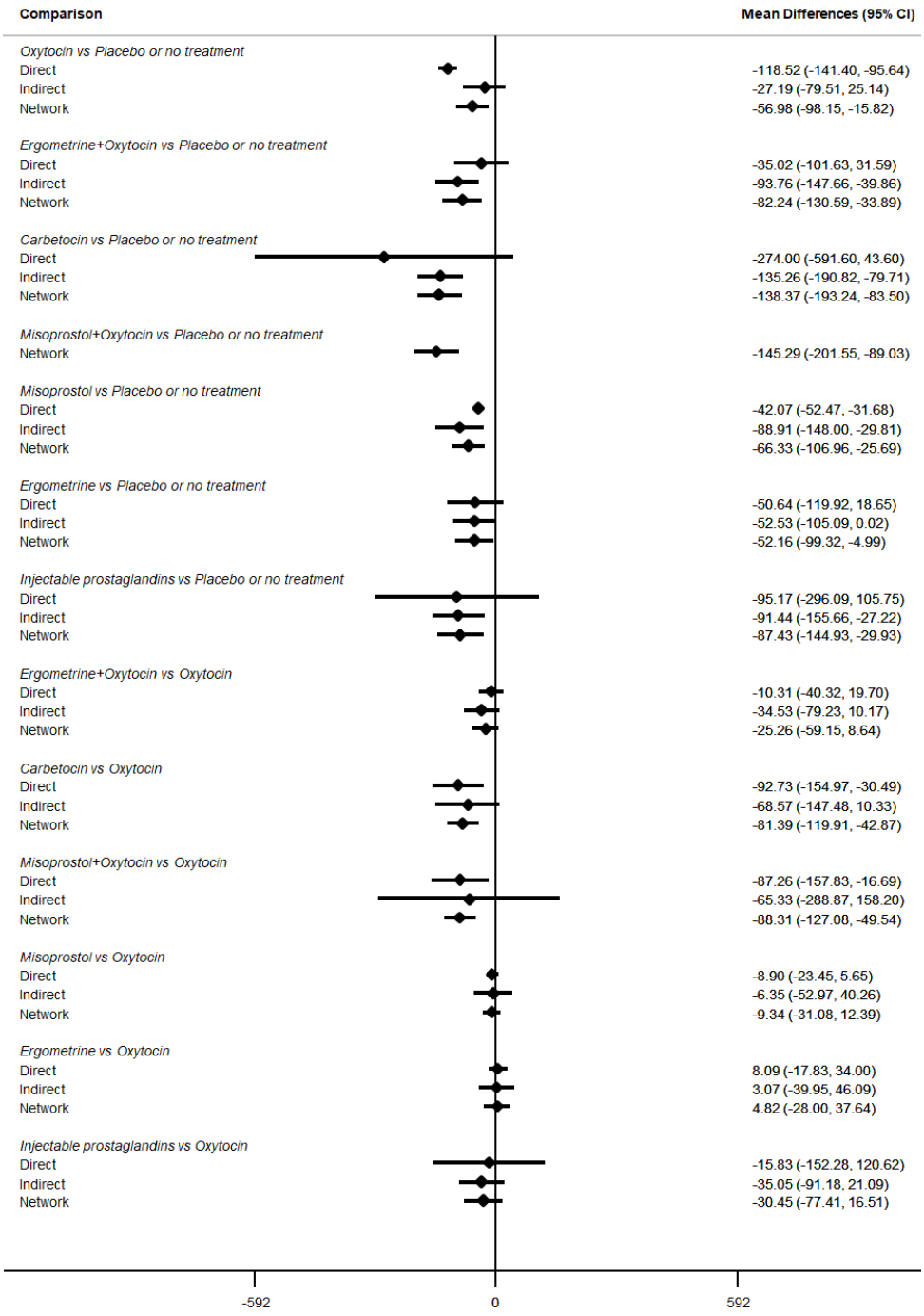
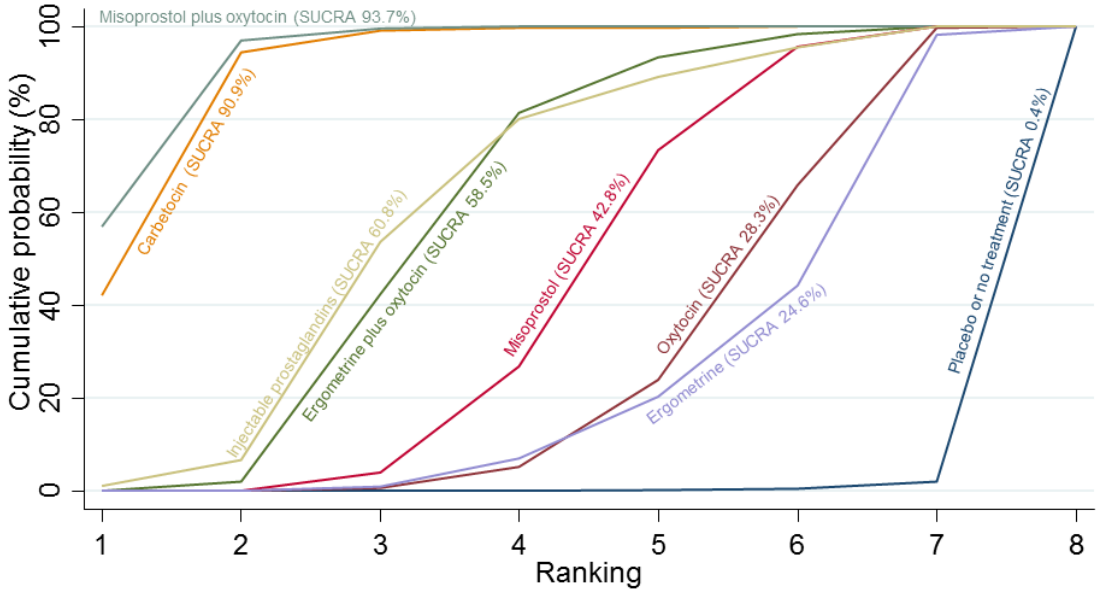


Figure 25 shows the cumulative probabilities for each agent being at each possible rank for preventing blood loss (mL) as a continuous outcome. The highest ranked agents were misoprostol plus oxytocin (SUCRA 93.7%), carbetocin (SUCRA 90.9%), injectable prostaglandins (SUCRA 60.8%) and ergometrine plus oxytocin (SUCRA 58.5%). Oxytocin was ranked sixth (SUCRA 28.3%) behind misoprostol (SUCRA 42.8%). The lowest ranked agents were ergometrine (SUCRA 24.6%) and placebo or no treatment (SUCRA 0.4%).

Figure 25. Cumulative rankograms comparing each of the uterotonic agents for mean blood loss (mL). Ranking indicates the cumulative probability of being the best, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Change in haemoglobin

The network diagram for the change in haemoglobin measurements before versus after birth (g/L) is presented in Figure 26. Relative effects from the network meta-analysis of 86 trials suggested that all agents except ergometrine and the injectable prostaglandins were effective for reducing the change in haemoglobin measurements when compared with placebo or no treatment (Figure 27). There is low-certainty evidence to suggest that the mean change in haemoglobin level before versus after birth may be lower among women receiving misoprostol plus oxytocin (MD 2.53 g/L lower, 95% CI 3.80 g/L lower to 1.26 g/L lower) and carbetocin (MD 2.18 g/L lower, 95% CI from 3.57 g/L lower to 0.79 g/L lower) compared with those receiving oxytocin. Low-certainty evidence suggests that there may be little or no difference between ergometrine (MD 0.98 g/L higher, 95% CI from 0.74 g/L lower to 2.69 g/L higher); or ergometrine plus oxytocin (MD 1.07 g/L lower, 95% CI 2.38 g/L lower to 0.25 g/L higher) and oxy-

tocin for this outcome. The effects of misoprostol and injectable prostaglandins were unclear because the certainty of the evidence was very low (Figure 27).

Figure 26. Network Diagram for change in haemoglobin measurements before and after birth (g/L). The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

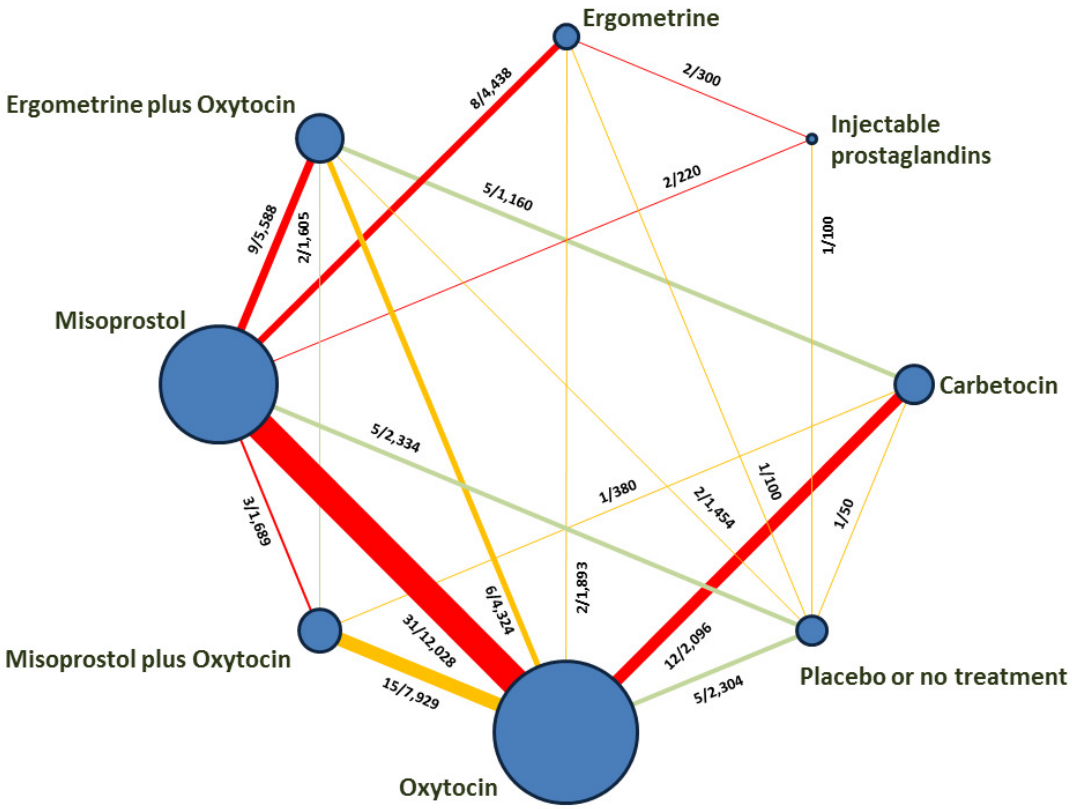


Figure 27. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for change in haemoglobin measurements before and after birth (g/L).

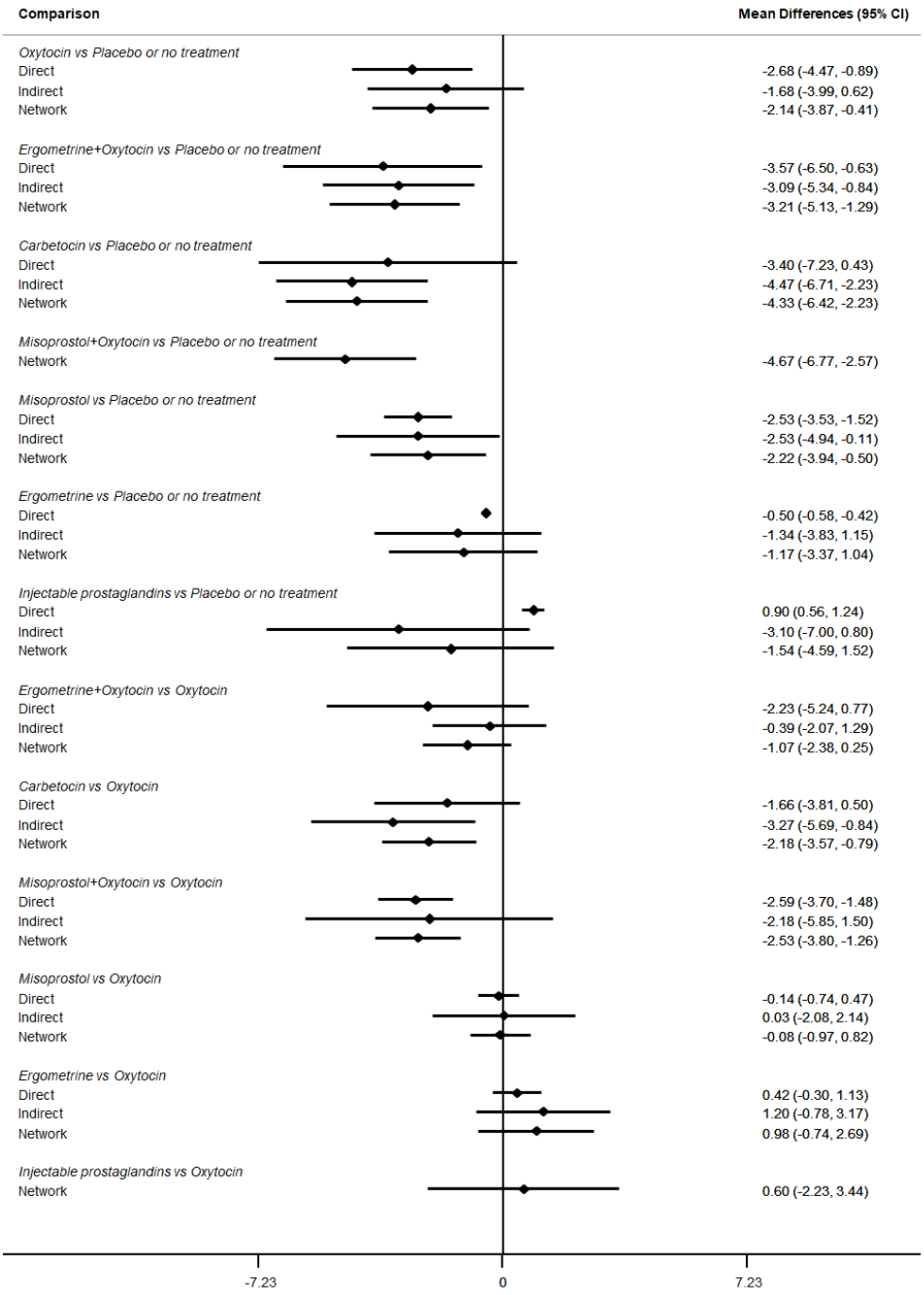
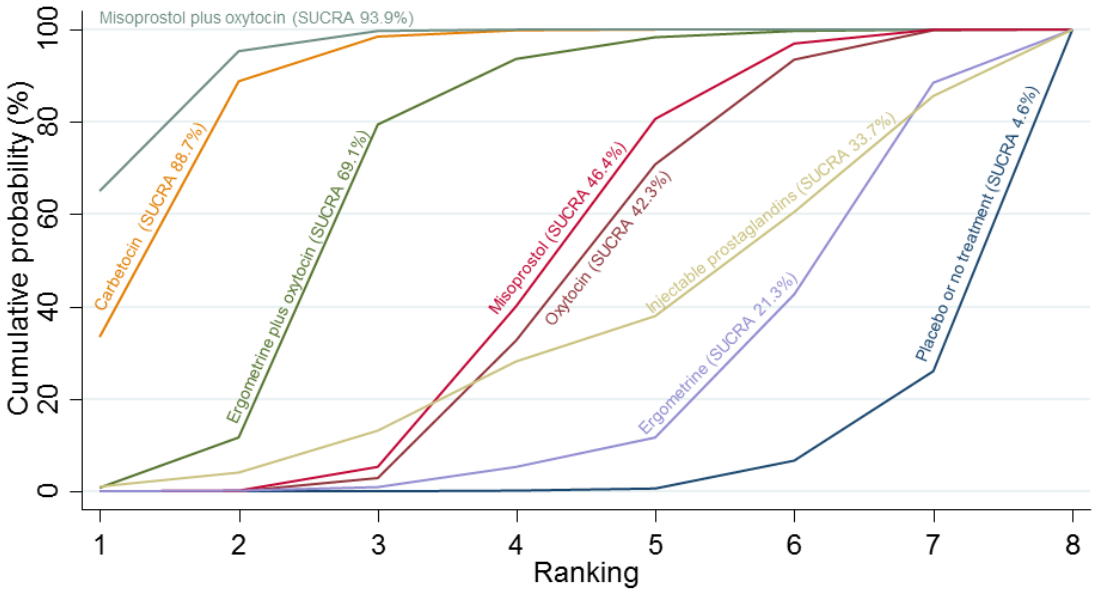


Figure 28 shows the cumulative probabilities for each agent being at each possible rank for change in haemoglobin measurements before versus after birth (g/L). The highest ranked agents were misoprostol plus oxytocin (93.9%), carbetocin (88.7%), and ergometrine plus oxytocin (69.1%). Oxytocin ranked fifth (SUCRA 42.3%) behind misoprostol (SUCRA 46.4%), but ranked better than injectable prostaglandins (SUCRA 33.7%), ergometrine (SUCRA 21.3%) and placebo or no treatment (SUCRA 4.6%).

Figure 28. Cumulative rankograms comparing each of the uterotonic s for change in haemoglobin measurements before and after birth (g/L). Ranking indicates the cumulative probability of being the best, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Breastfeeding at hospital discharge

The network diagram for breastfeeding at hospital discharge is presented in Figure 29. Relative effects from the network meta-analysis of six trials suggested that there were no detectable differences among oxytocin, carbetocin, ergometrine plus oxytocin for breastfeeding at hospital discharge when compared with placebo or no treatment. HIgh-certainty evidence suggests that ergometrine plus oxytocin (RR 0.99, 95% CI 0.96 to 1.03) makes little or no difference to the proportion of women who are breastfeeding at the time of discharge from hospital when compared with oxytocin. In absolute terms, these results suggest that about 849 per 1000 women given oxytocin for vaginal birth would be breastfeeding at discharge, compared to 841 per 1000 women with ergometrine plus oxytocin. The findings for carbetocin were unclear, because we found the evidence to be of very low certainty. There were no clear findings relating to any other uterotonics as the outcome was not reported in any of the included trials involving misoprostol, injectable prostaglandins, ergometrine and misoprostol plus oxytocin (Figure 30).

Figure 29. Network Diagram for breastfeeding at discharge. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

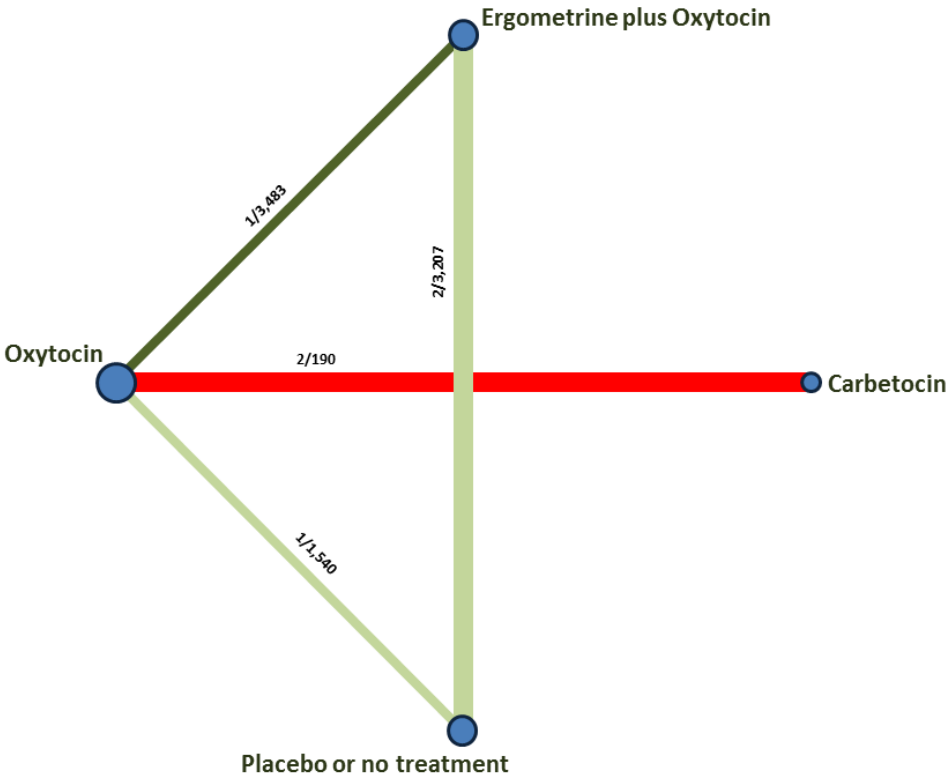


Figure 30. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for breastfeeding at discharge.

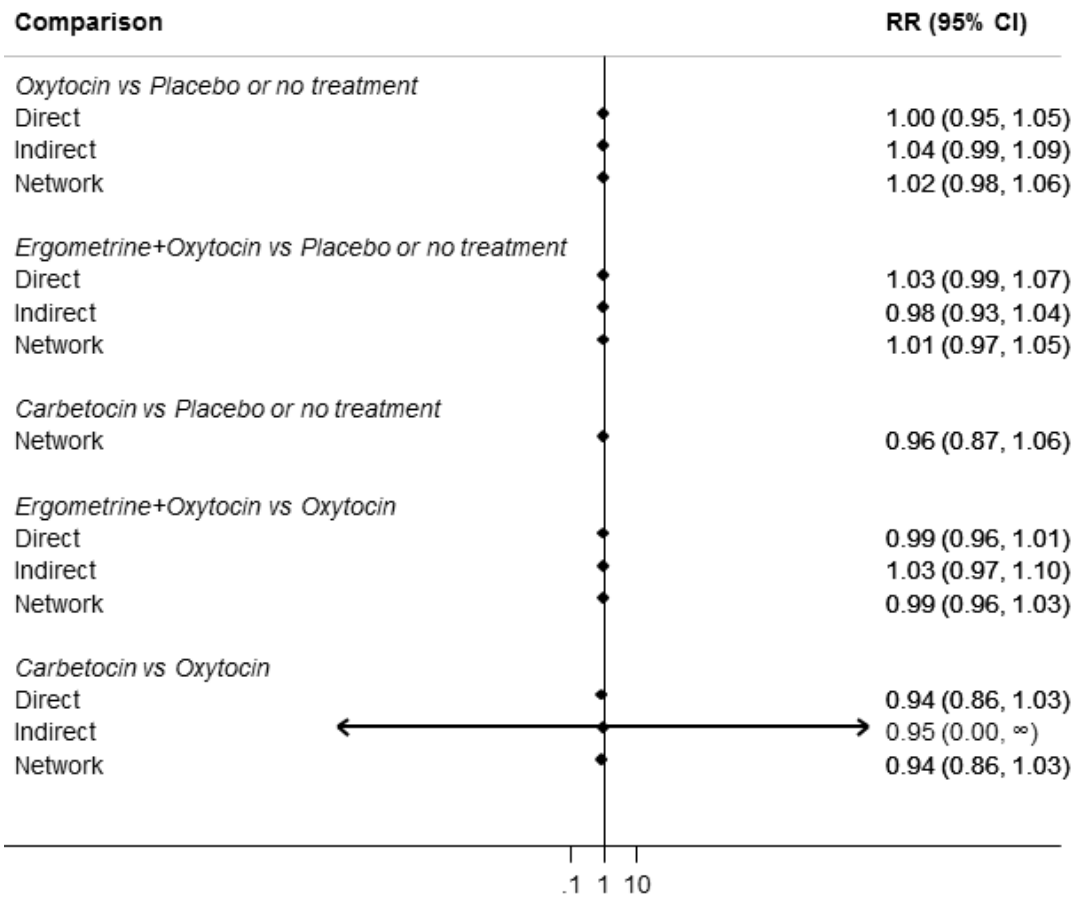
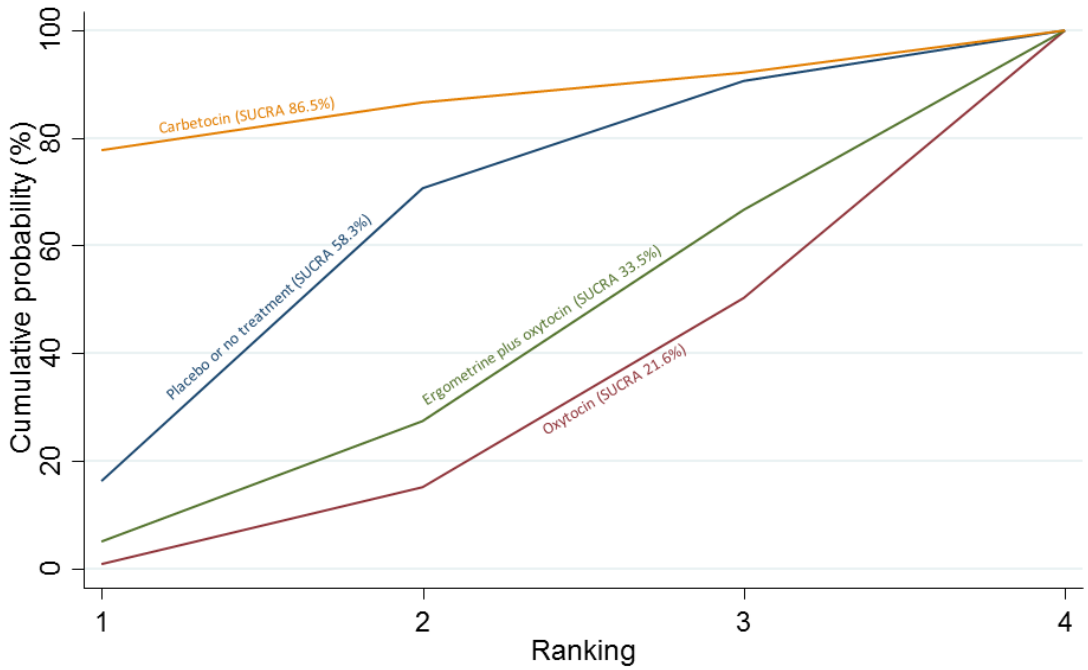


Figure 31 shows the cumulative probabilities for each agent being at each possible rank for breastfeeding at hospital discharge. The ranking for all agents was not clear for this outcome due to limited data.

Figure 31. Cumulative rankograms comparing each of the uterotonic agents for breastfeeding at discharge. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Side effects

Nausea

The network diagram for nausea is presented in Figure 32. Relative effects from the network meta-analysis of 100 trials suggest that ergometrine and ergometrine plus oxytocin are worse than placebo or no treatment in causing nausea (Figure 33). When compared with oxytocin, there is high-certainty evidence to suggest that women receiving ergometrine plus oxytocin (RR 2.03, 95% CI 1.47 to 2.80) and misoprostol plus oxytocin (RR 1.88, 95% CI 1.14 to 3.09) are more likely to experience nausea and moderate-certainty evidence that women receiving misoprostol (RR 1.41, 95% CI 1.10 to 1.81), ergometrine (RR 2.40, 95% CI 1.65 to 3.49) or injectable prostaglandins (RR 2.25, 95% CI 1.16 to 4.39) are more likely to experience nausea than women receiving oxytocin alone (Figure 33). Based on these results, about 86 per 1000 women given oxytocin for a vaginal birth would experience nausea, compared with 175 given ergometrine plus oxytocin, 162 given misoprostol plus oxytocin, 121 given misoprostol, 206 given ergometrine, and 193 given injectable prostaglandins. Low-certainty evidence suggests that carbetocin may make little or no difference to experience of nausea among women when compared with oxytocin (RR 1.00, 95% CI 0.71 to 1.41). With carbetocin, the anticipated absolute effect is the same as oxytocin, with 86 per 1000 women experiencing nausea.

Figure 32. Network Diagram for nausea. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

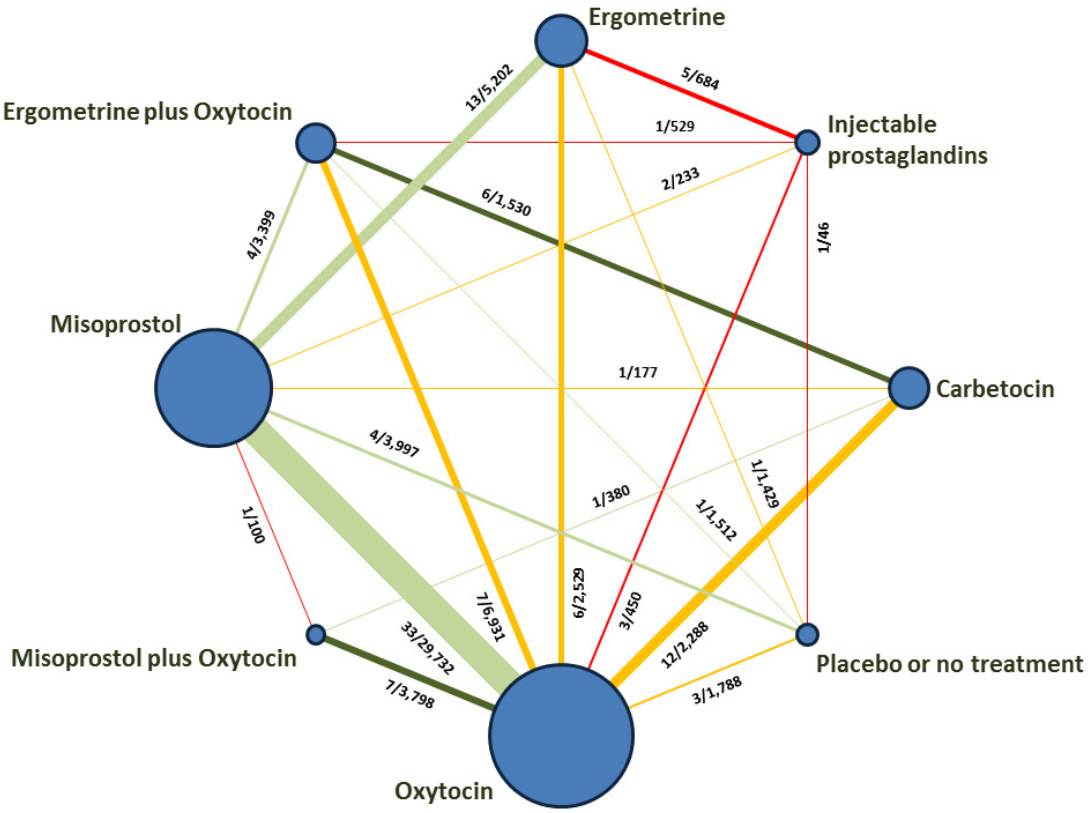


Figure 33. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for nausea.

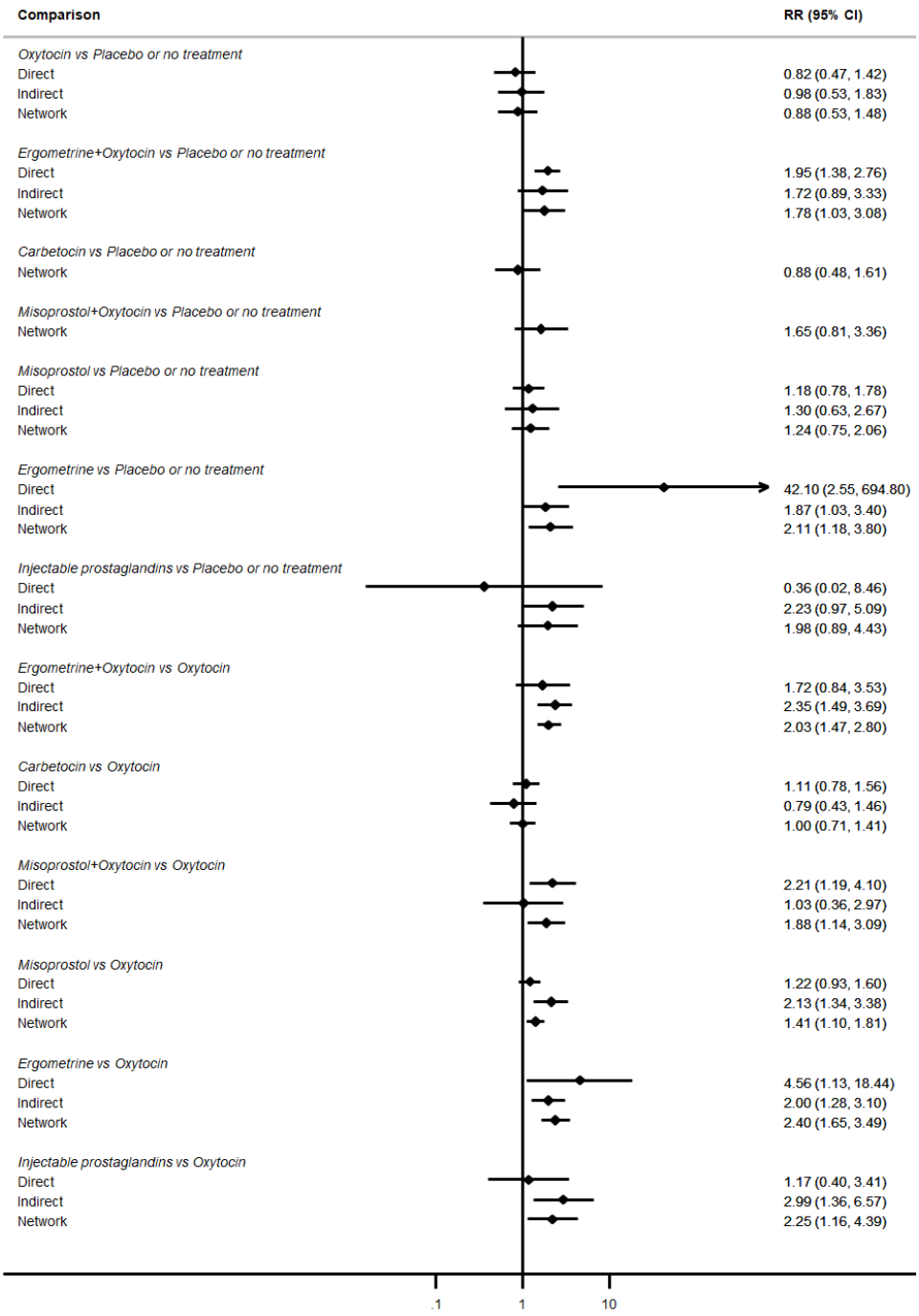
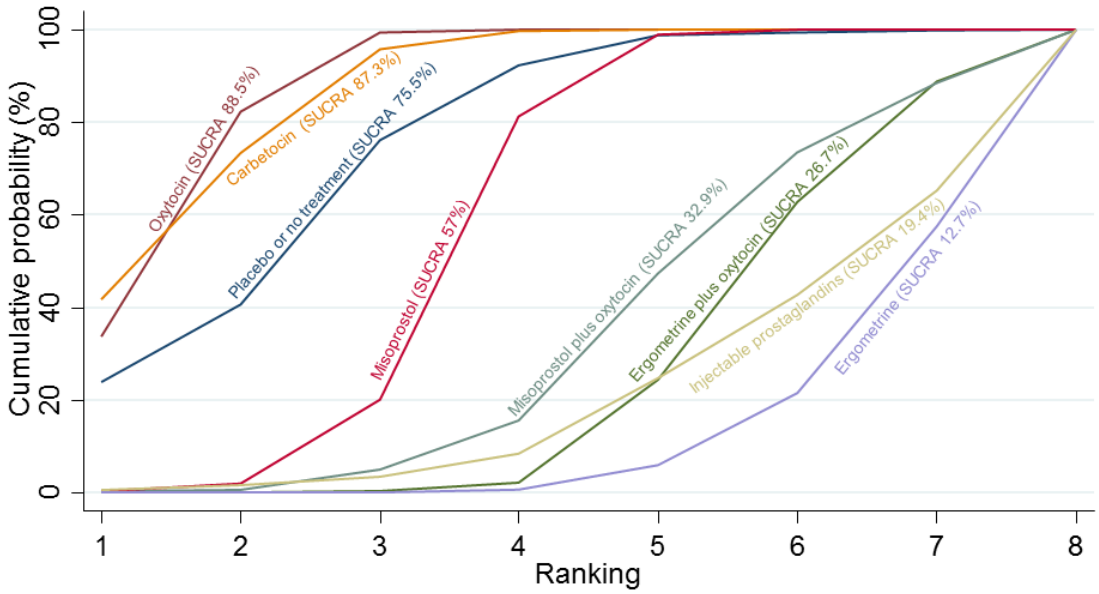


Figure 34 shows the cumulative probabilities for each agent being at each possible rank for causing nausea. The highest ranked agents with which women are less likely to experience nausea are oxytocin (SUCRA 88.5%), carbetocin (SUCRA 87.3%) and placebo or no treatment (SUCRA 75.5%). These are followed by misoprostol (SUCRA 57%) and misoprostol plus oxytocin (SUCRA 32.9%). The lowest ranked agents are ergometrine plus oxytocin (SUCRA 26.7%), injectable prostaglandins (SUCRA 19.4%) and ergometrine (SUCRA 12.7%).

Figure 34. Cumulative rankograms comparing each of the uterotonic agents for nausea. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SURface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Vomiting

The network diagram for vomiting is presented in Figure 35. Relative effects from the network meta-analysis of 110 trials suggested that ergometrine, injectable prostaglandins, misoprostol plus oxytocin and ergometrine plus oxytocin are worse than placebo or no treatment in causing vomiting (Figure 36). When compared with oxytocin, there is evidence that all agents besides carbetocin increase the incidence of vomiting. High-certainty evidence suggests misoprostol plus oxytocin combination (RR 2.11, 95% CI 1.39 to 3.18) increases the likelihood of vomiting, while moderate-certainty evidence suggests that ergometrine plus oxytocin (RR 2.93, 95% CI 2.08 to 4.13), misoprostol (RR 1.63, 95% CI 1.25 to 2.14), and ergometrine (RR 2.36, 95% CI 1.56 to 3.55) probably increase the likelihood of vomiting. These results suggest that 13 per 1000 women given oxytocin experience vomiting, compared to 12 per 1000 with carbetocin, 27 with misoprostol plus oxytocin, 38 with ergometrine plus oxytocin, 21 with misoprostol, and 31 with ergometrine. Low-certainty evidence also suggests that injectable prostaglandins (RR 3.76, 95% CI 1.90 to 7.42)

may increase women's experience of vomiting. Moderate-certainty evidence suggests that carbetocin probably makes little or no difference to women's experience of vomiting compared with oxytocin (RR 0.93, 95% CI 0.64 to 1.35) (Summary of findings 5).

Figure 35. Network Diagram for vomiting. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

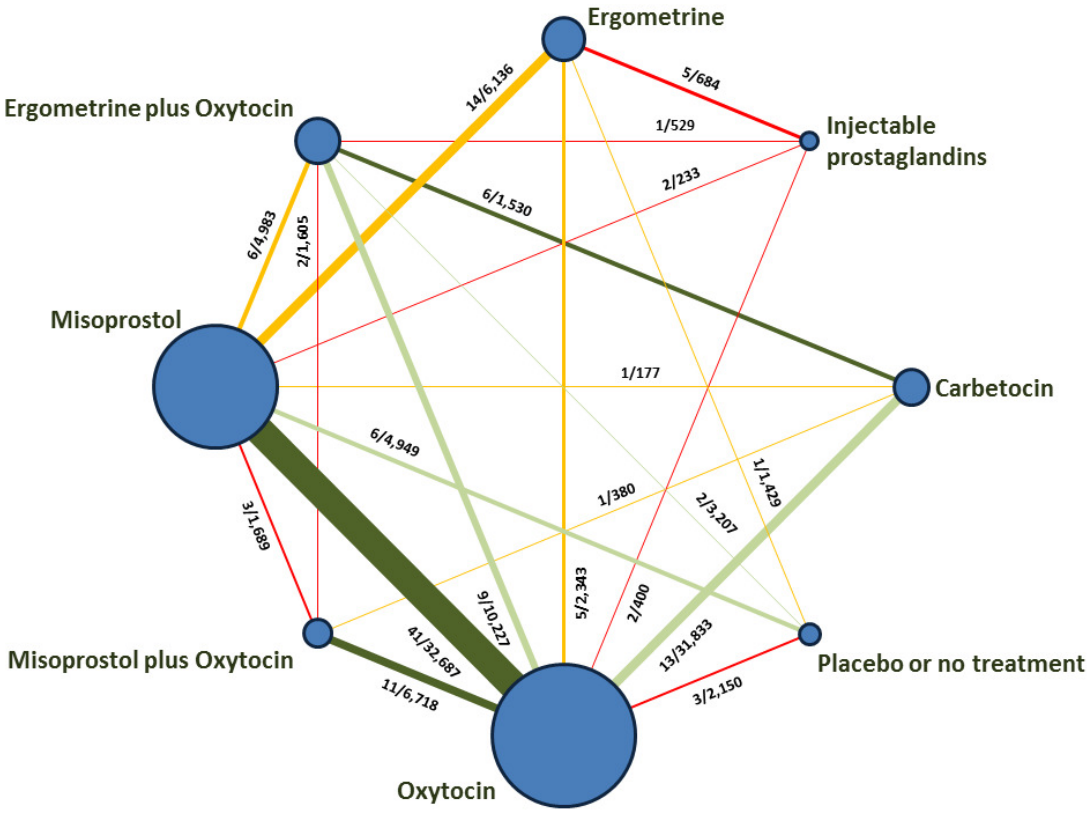


Figure 36. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for vomiting.

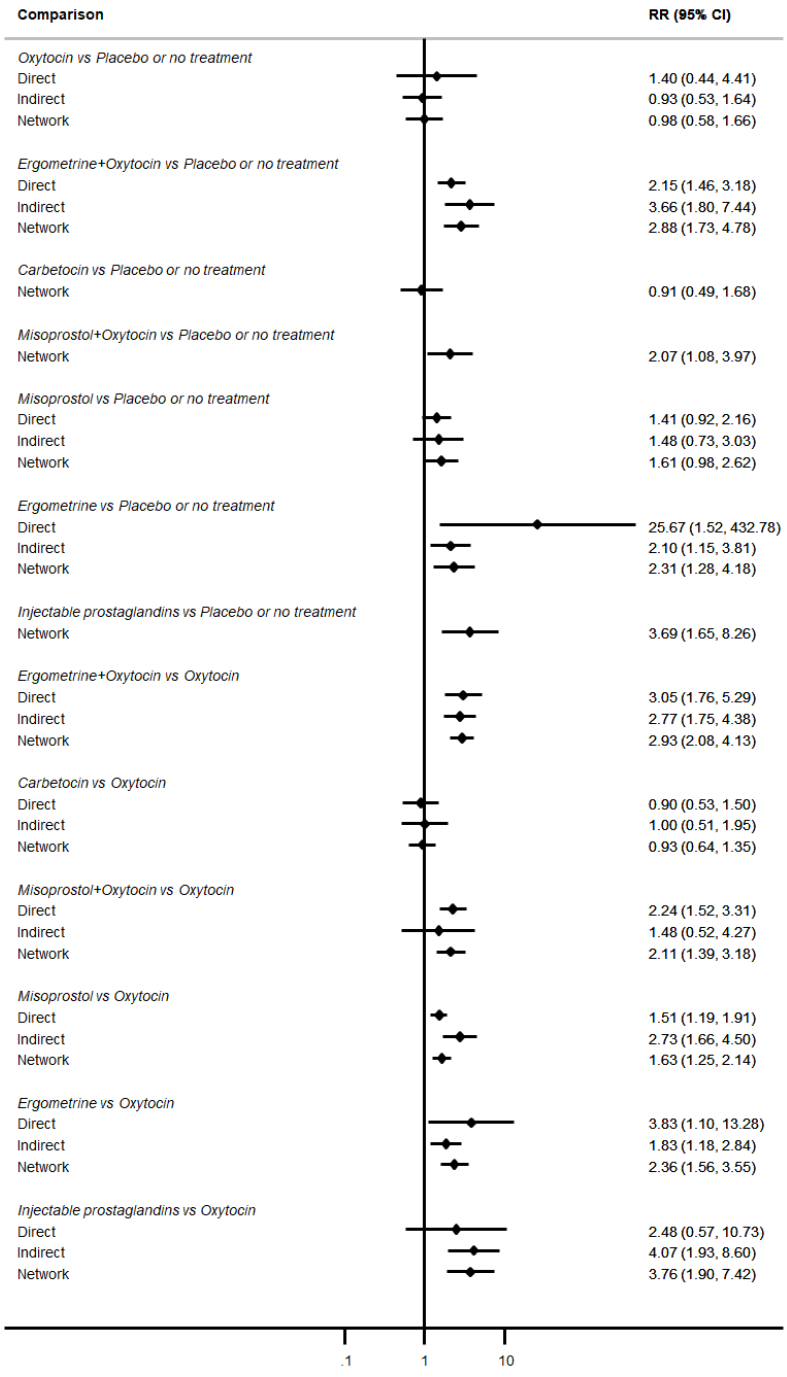
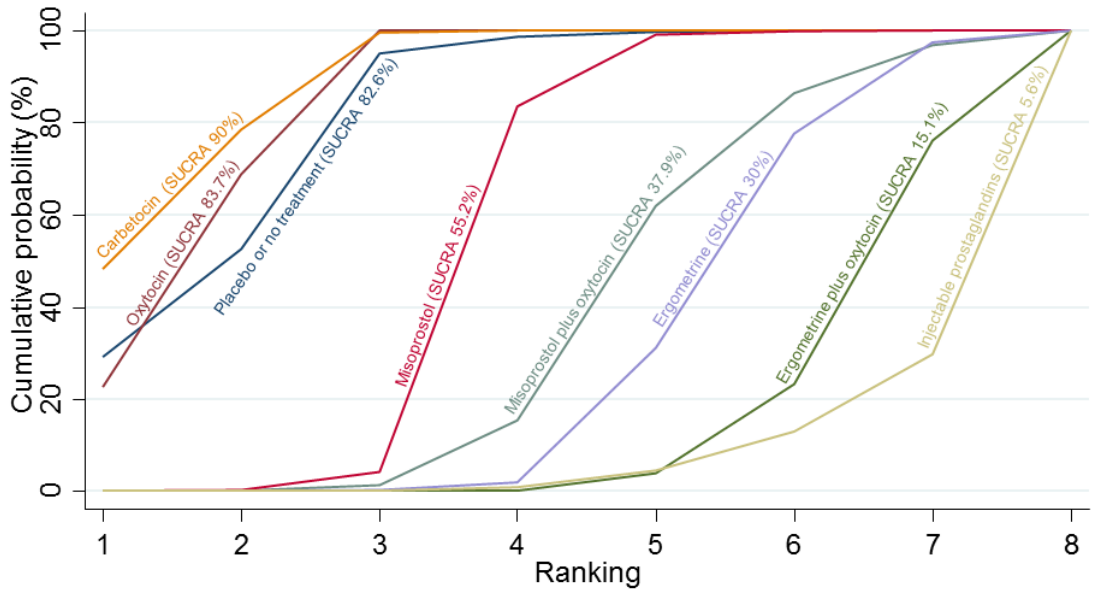


Figure 37 shows the cumulative probabilities for each agent being at each possible rank for causing vomiting. The highest ranked agents were carbetocin (SUCRA 90%), oxytocin (SUCRA 83.7%) and placebo or no treatment (SUCRA 82.6%). These are followed by misoprostol (SUCRA 55.2%) and misoprostol plus oxytocin (SUCRA 37.9%). The lowest ranked agents were ergometrine (SUCRA 30%), ergometrine plus oxytocin (SUCRA 15.1%) and injectable prostaglandins (SUCRA 5.6%).

Figure 37. Cumulative rankograms comparing each of the uterotonic agents for vomiting. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Hypertension

The network diagram for hypertension is presented in Figure 38. Relative effects from the network meta-analysis of 20 trials suggest that ergometrine is worse than placebo or no treatment in causing hypertension (Figure 39). Low-certainty evidence suggests that ergometrine (RR 8.54, 95% CI 2.12 to 34.48) may increase the risk of hypertension when compared with oxytocin, whereas misoprostol (RR 1.50, 95% 0.49 to 4.61) and ergometrine plus oxytocin (RR 2.48, 95% CI 0.89 to 6.88) may make little or no difference to this outcome. The baseline risk of hypertension for women receiving oxytocin is 76 per 1000 women. Taking into account the very wide 95% CIs, this suggests that the range of possible true effects varies substantially for each agent. It is uncertain whether carbetocin or injectable prostaglandins increase hypertension because the certainty of evidence was very low (Summary of findings 6).

Figure 38. Network Diagram for hypertension. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

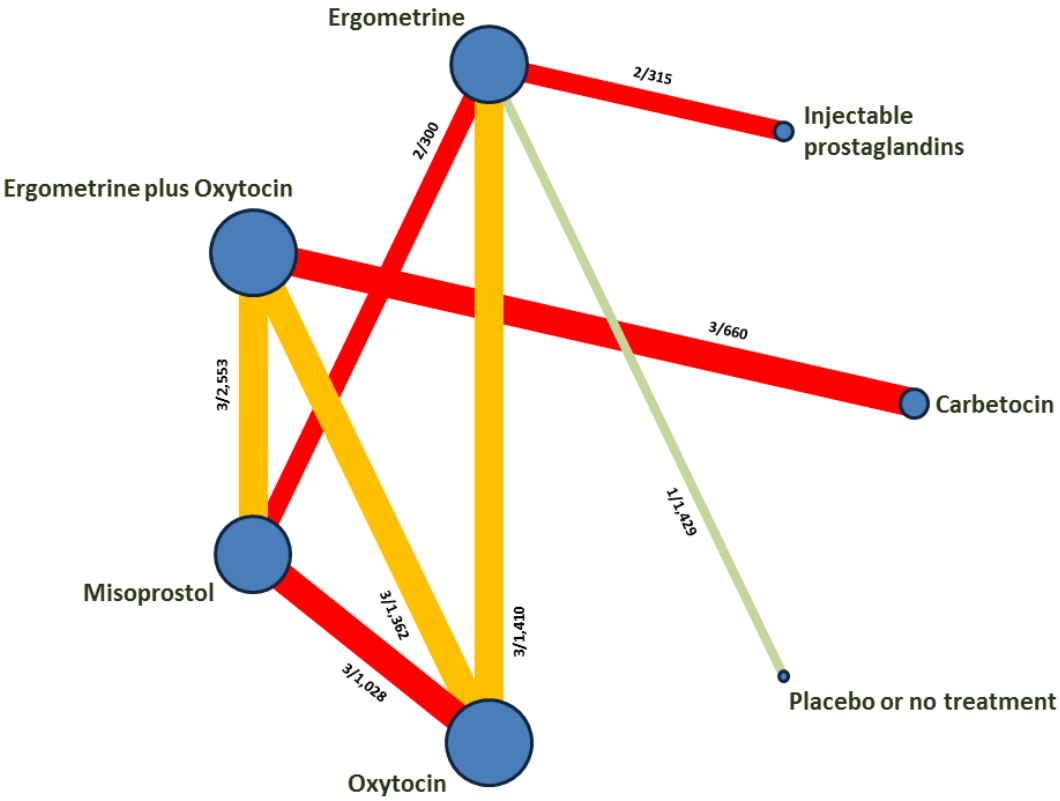


Figure 39. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for hypertension.

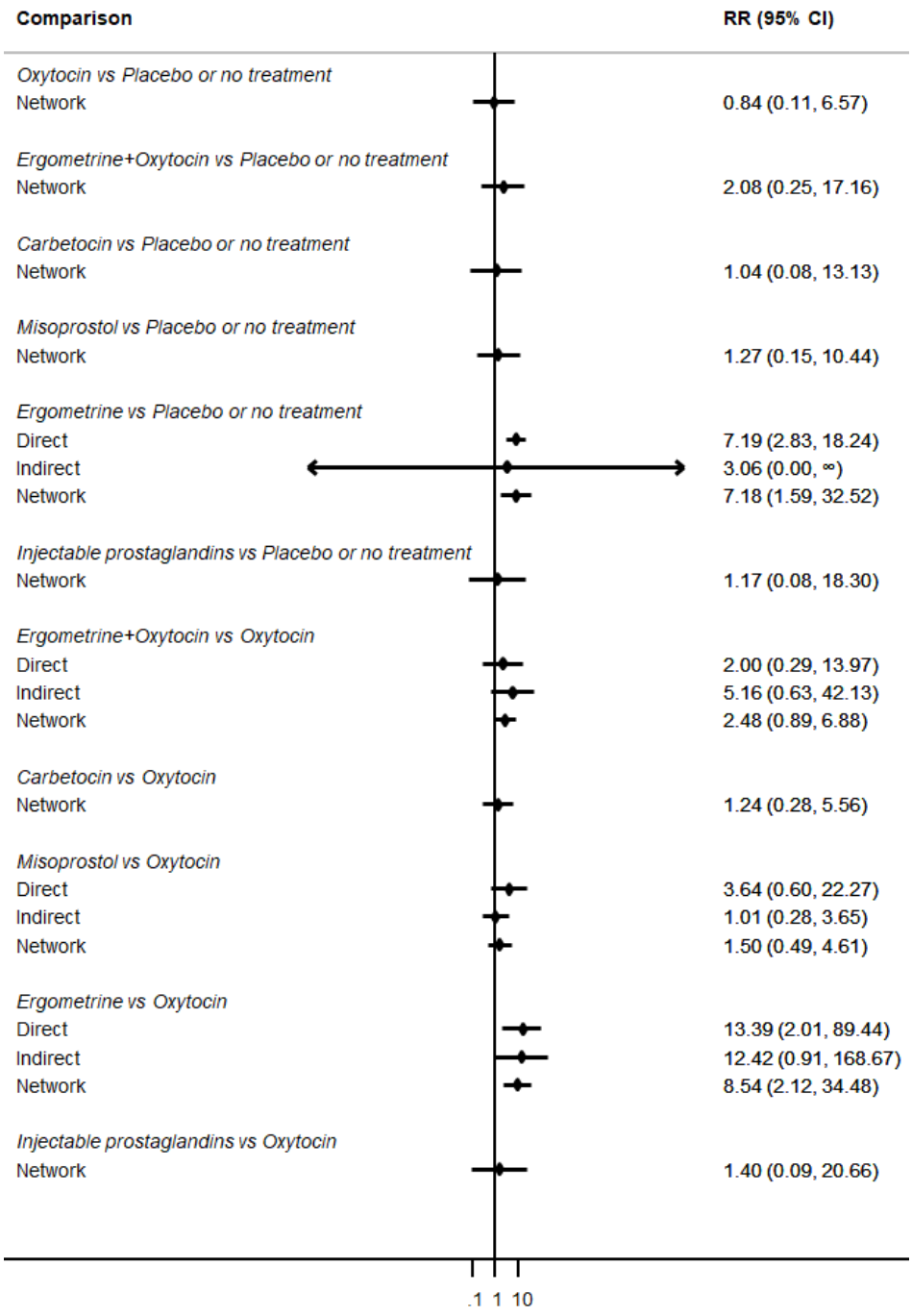
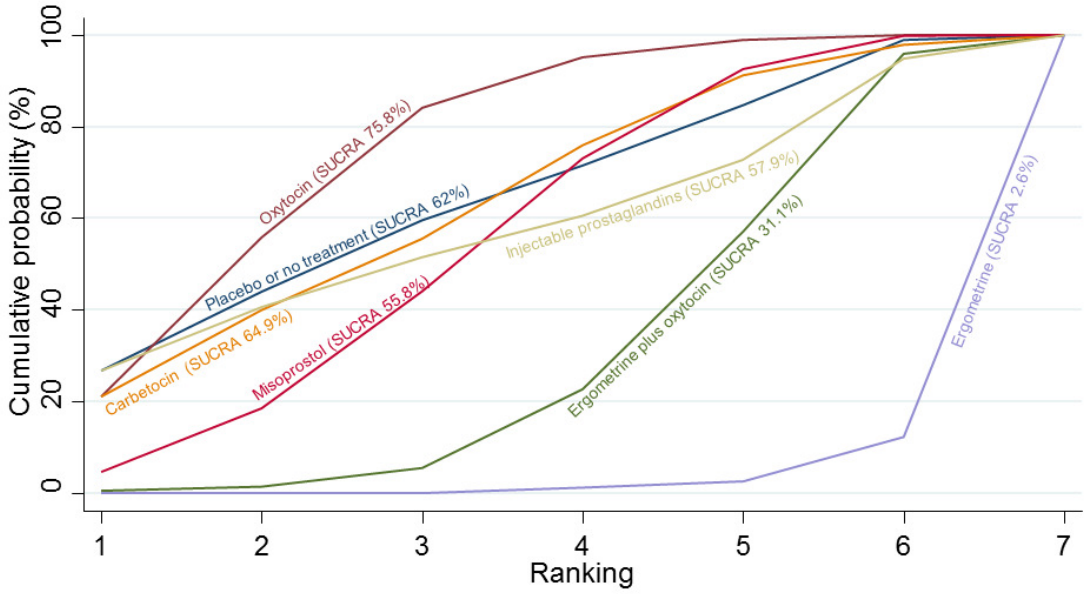


Figure 40 shows the cumulative probabilities for each agent being at each possible rank for causing hypertension. The lowest ranked agents were ergometrine (SUCRA 2.6%) and ergometrine plus oxytocin (31.1%). The rest of the agents were of comparable ranking. There were no trials involving misoprostol plus oxytocin so this agent could not be ranked.

Figure 40. Cumulative rankograms comparing each of the uterotonic agents for hypertension. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Headache

The network diagram for headache is presented in Figure 41. Relative effects from the network meta-analysis of 57 trials suggested that ergometrine is worse than placebo or no treatment in causing headache (Figure 42). When compared with oxytocin, there is low-certainty evidence to suggest that women receiving ergometrine (RR 1.89, 95% CI 1.02 to 3.50) may be more likely to experience headache (Figure 42), with 167 per 1000 women given oxytocin experiencing headache compared to 316 with ergometrine. Low-certainty evidence also suggests that carbetocin, misoprostol, and misoprostol plus oxytocin may make little or no difference to experience of headache when compared with oxytocin. It is uncertain whether injectable prostaglandins impact on women's experience of headache because the certainty of evidence was very low.

Figure 41. Network Diagram for headache. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

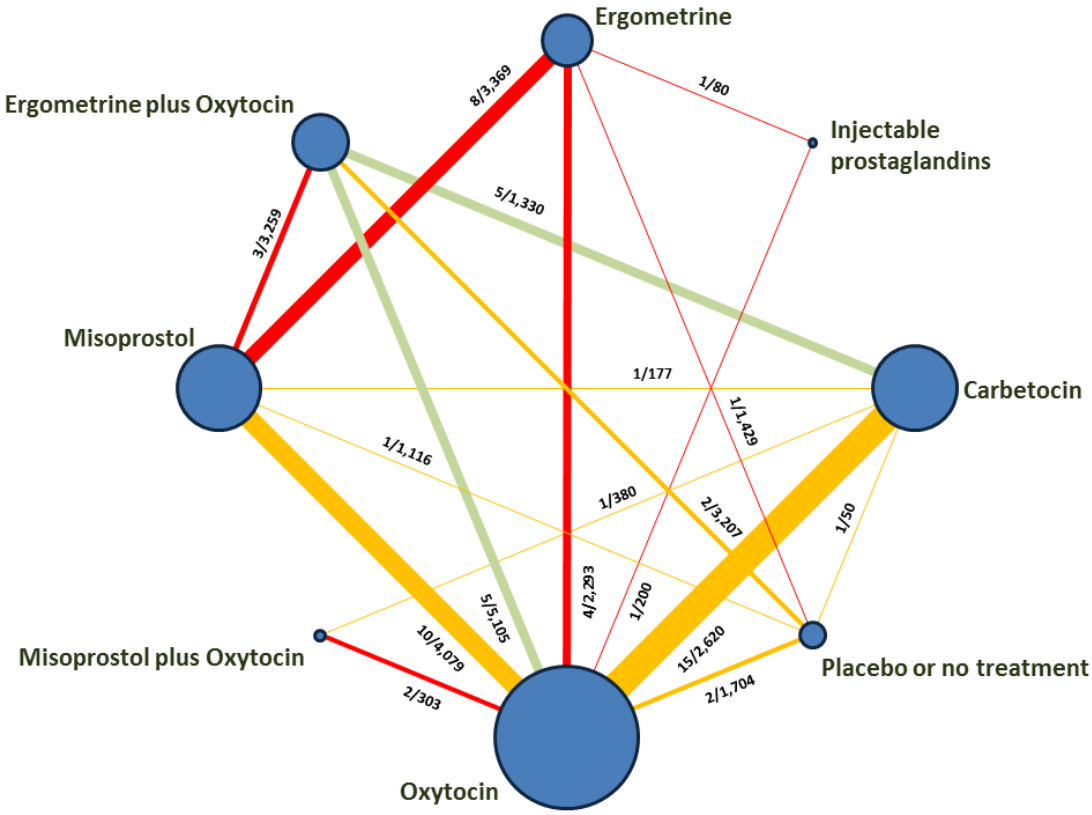


Figure 42. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for headache.

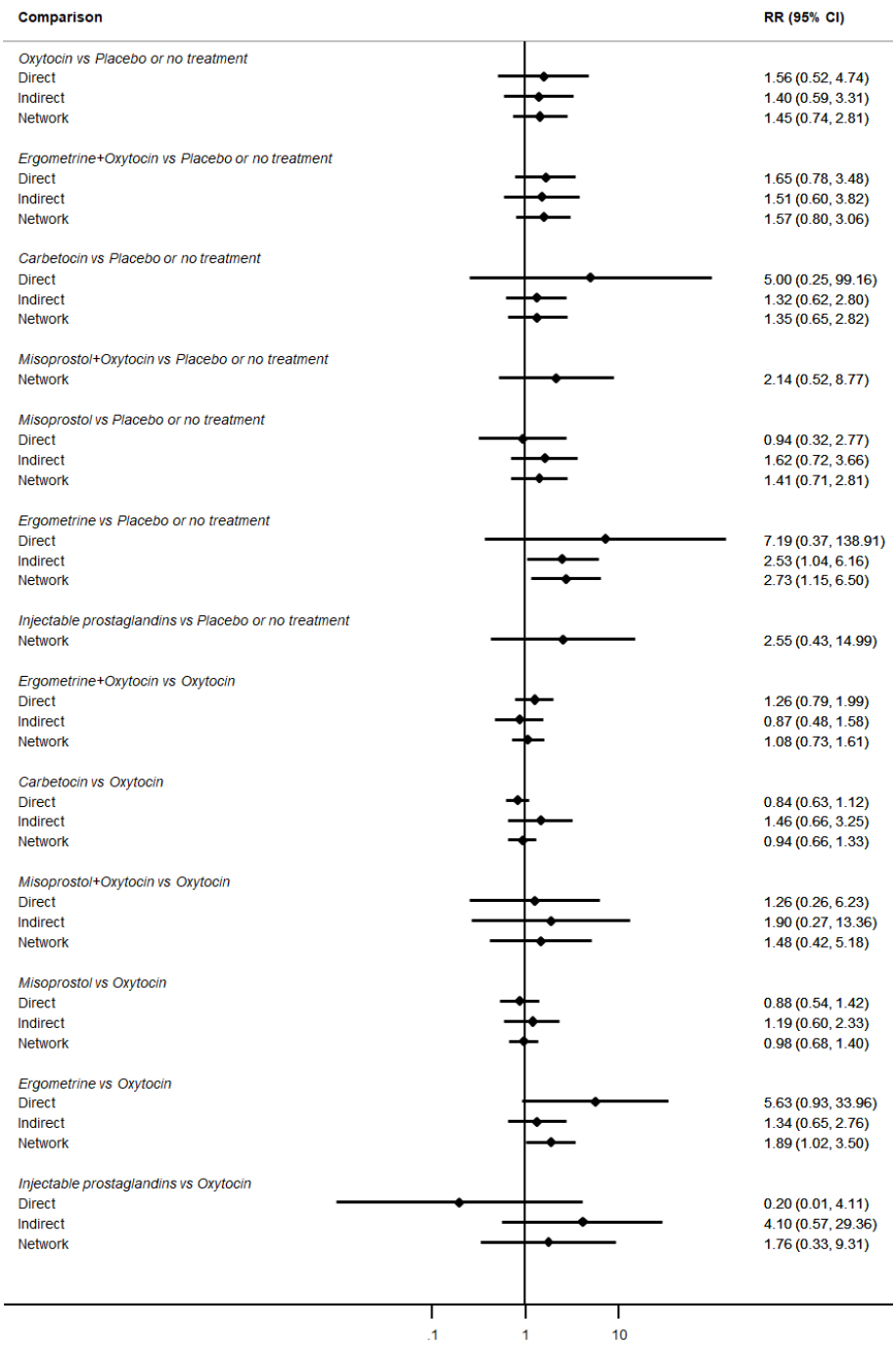
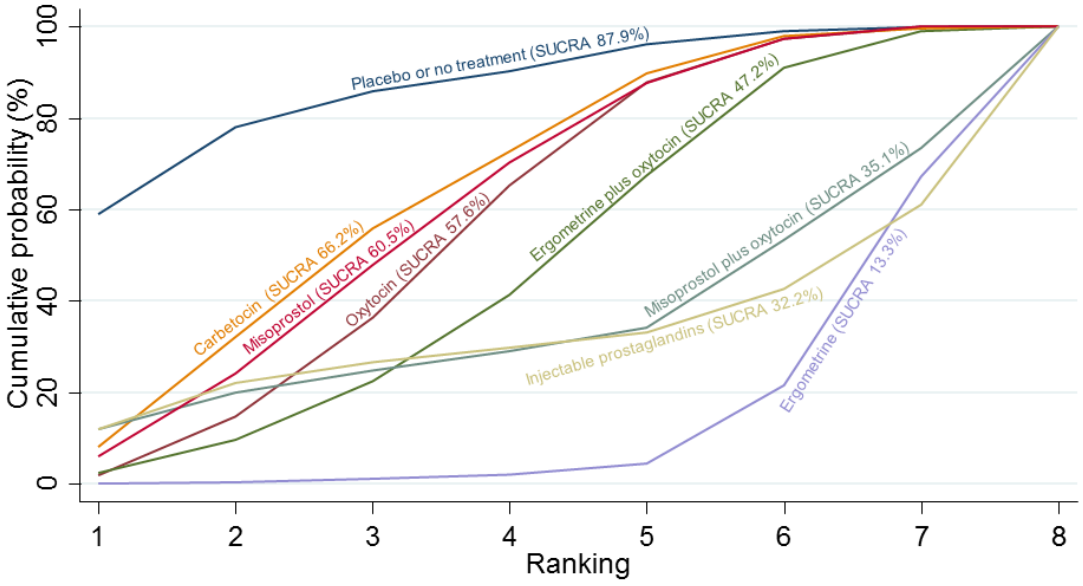


Figure 43 shows the cumulative probabilities for each agent being at each possible rank for causing headache. The highest ranked intervention was placebo or no treatment (SUCRA 87.9%), carbetocin (SUCRA 66.2%), misoprostol (SUCRA 60.5%) and oxytocin (SUCRA 57.6%). The lowest ranked agents were ergometrine plus oxytocin (SUCRA 47.2%), misoprostol plus oxytocin (SUCRA 35.1%), injectable prostaglandins (SUCRA 32.2%) and ergometrine (SUCRA 13.3%).

Figure 43. Cumulative rankograms comparing each of the uterotonic agents for headache. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Fever

The network diagram for fever is presented in Figure 44. Relative effects from the network meta-analysis of 83 trials suggested that misoprostol and misoprostol plus oxytocin are worse than placebo or no treatment in causing fever (Figure 45). Moderate-certainty evidence suggests that misoprostol (RR 3.87, 95% CI 2.90 to 5.16) and misoprostol plus oxytocin (RR 3.14, 95% CI 2.20 to 4.49) probably increase the occurrence of fever when compared with oxytocin. Moderate-certainty evidence suggests that carbetocin (RR 1.07, 95% CI 0.43 to 2.69) probably makes little or no difference to women's experience of fever. These results suggests that 24 per 1000 women given oxytocin would experience fever, compared to 93 with misoprostol, 75 with misoprostol plus oxytocin and 26 with carbetocin. Low-certainty evidence suggests that injectable prostaglandins (RR 1.12, 95% CI 0.33 to 3.86) and ergometrine plus oxytocin (RR 0.70, 95% CI 0.35 to 1.42) may make little or no difference to this outcome, when compared

with oxytocin. Evidence regarding the comparative effect of ergometrine on this outcome is uncertain because the certainty of the evidence was very low (Summary of findings 7).

Figure 44. Network Diagram for fever. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

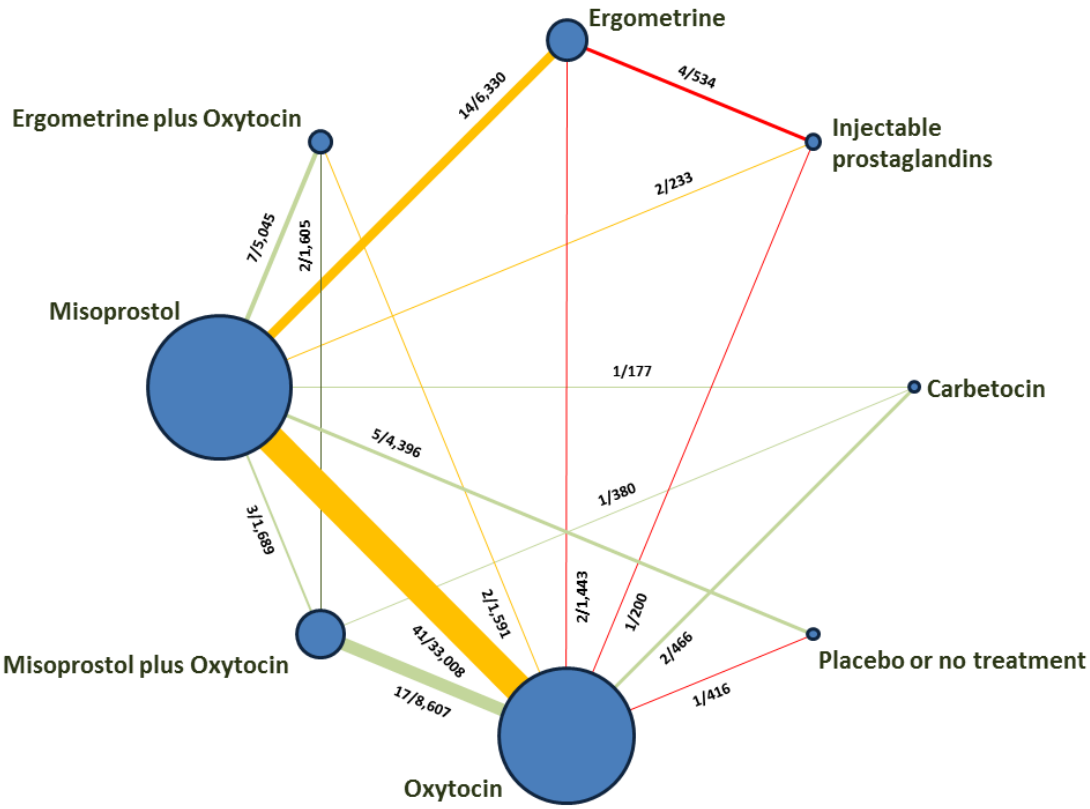


Figure 45. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for fever.

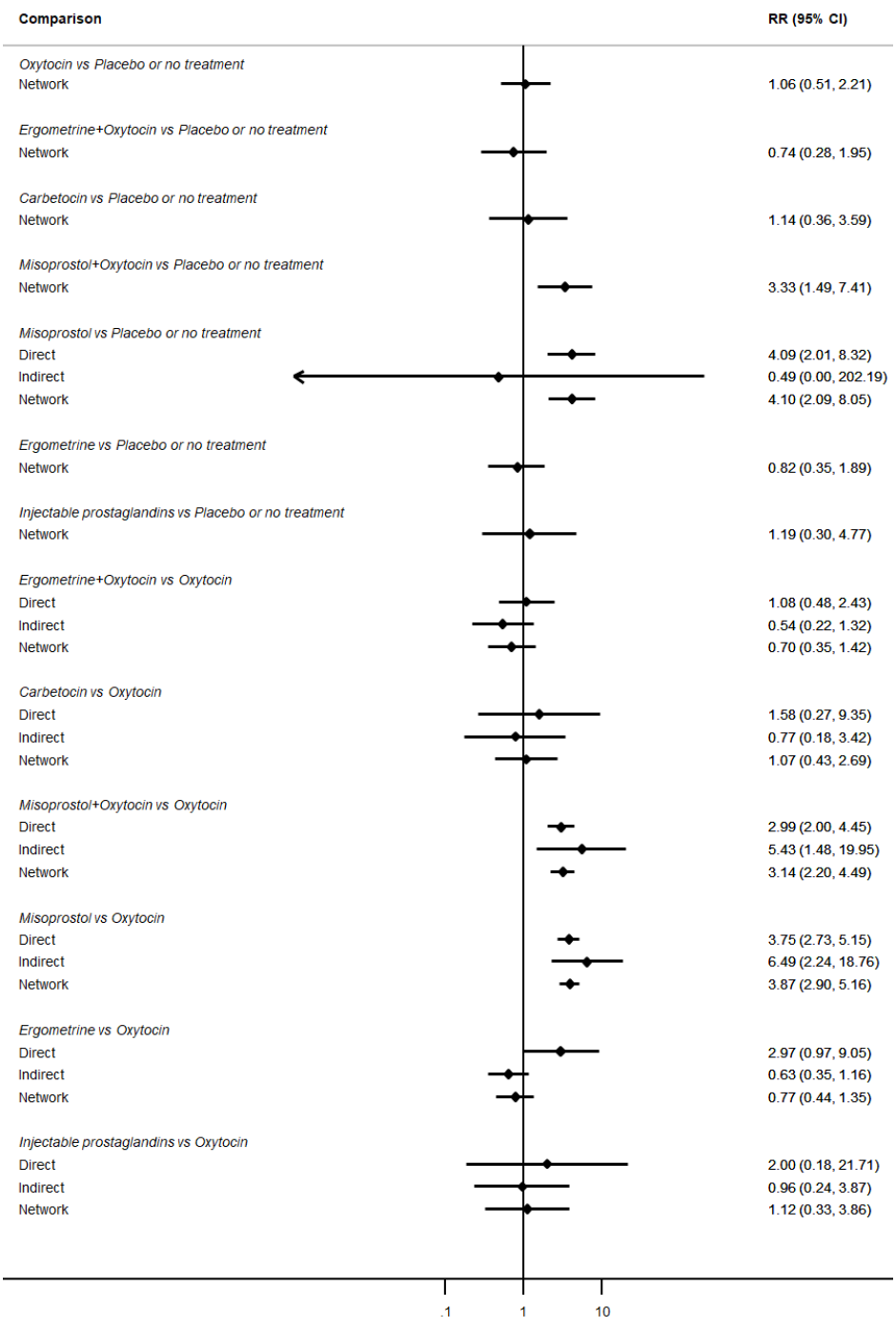
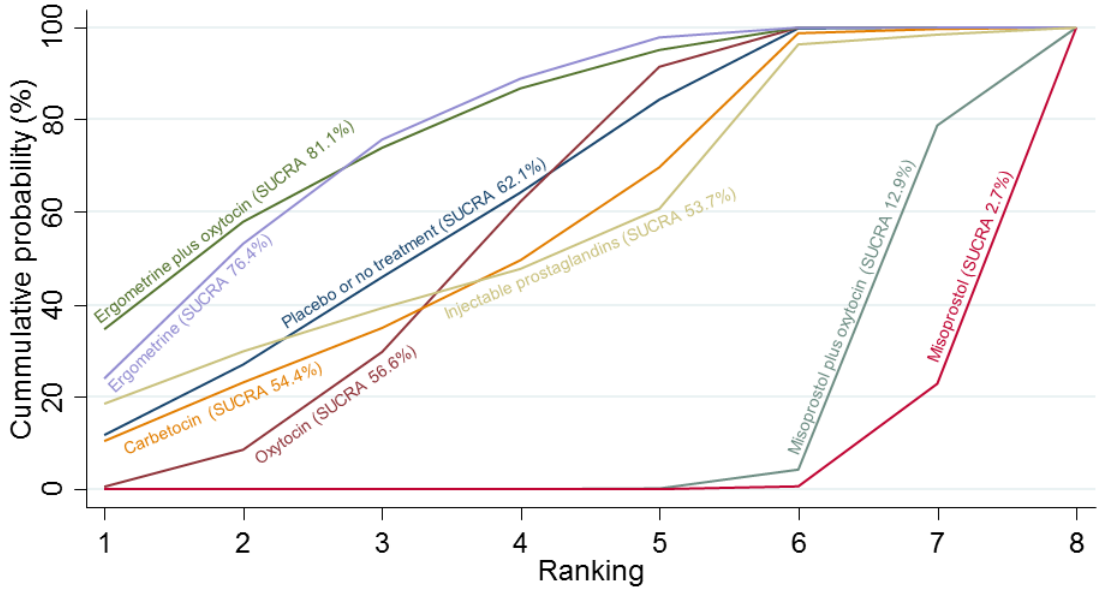


Figure 46 shows the cumulative probabilities for each agent being at each possible rank for causing fever. The lowest ranked agents were misoprostol (SUCRA 2.7%) and misoprostol plus oxytocin (SUCRA 12.9%). The rest of the agents were similar in ranking to the placebo or no treatment group.

Figure 46. Cumulative rankograms comparing each of the uterotonic agents for fever. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Shivering

The network diagram for shivering is presented in Figure 47. Relative effects from the network meta-analysis of 109 trials suggested that misoprostol and misoprostol plus oxytocin are worse than placebo or no treatment in causing shivering (Figure 48). When compared with oxytocin, there is moderate-certainty evidence to suggest that women receiving misoprostol plus oxytocin (RR 3.62, 95% CI 2.59 to 5.05) are probably more likely to experience shivering (Figure 48). In absolute terms, whereas 89 per 1000 women given oxytocin would experience shivering with oxytocin, 322 would experience shivering with misoprostol plus oxytocin. Low-certainty evidence suggests that misoprostol (RR 4.18, 95% CI 3.34 to 5.23) may also increase the experience of shivering. Moderate-certainty evidence suggests that ergometrine plus oxytocin (RR 1.38, 95% CI 0.86 to 2.22) probably makes little or no difference to shivering when compared with oxytocin. Likewise, low-certainty evidence suggests that carbetocin and injectable prostaglandins may make little or no difference to this outcome when compared with oxytocin (Figure 48).

Figure 47. Network Diagram for shivering. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

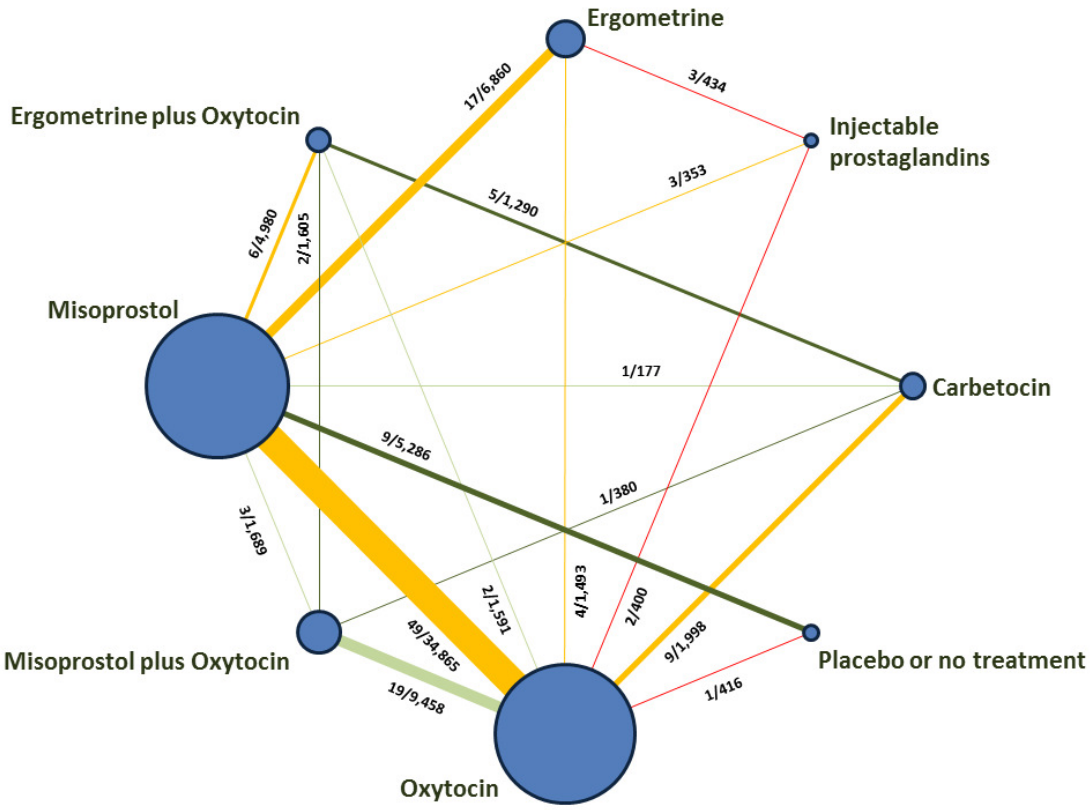


Figure 48. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for shivering.

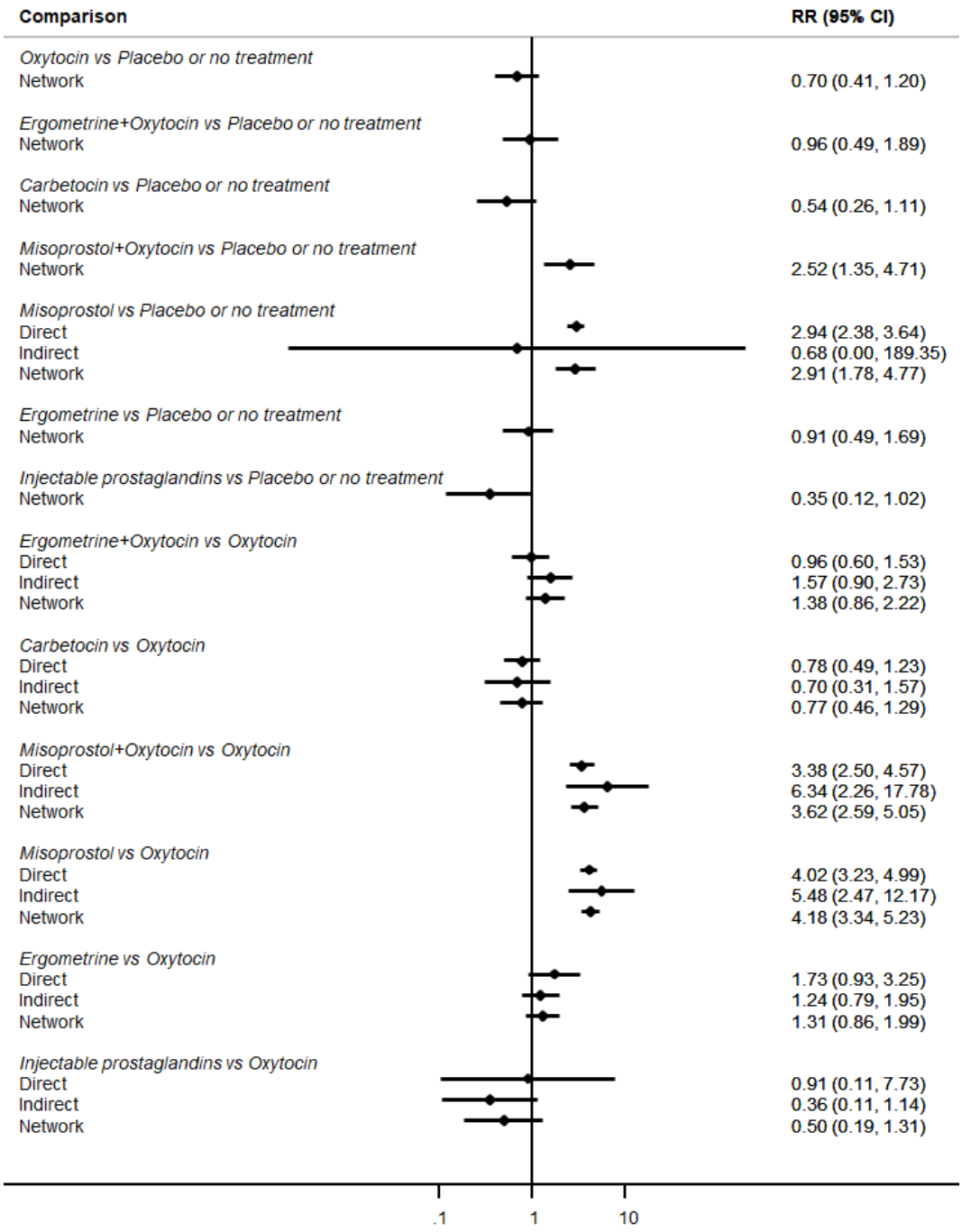
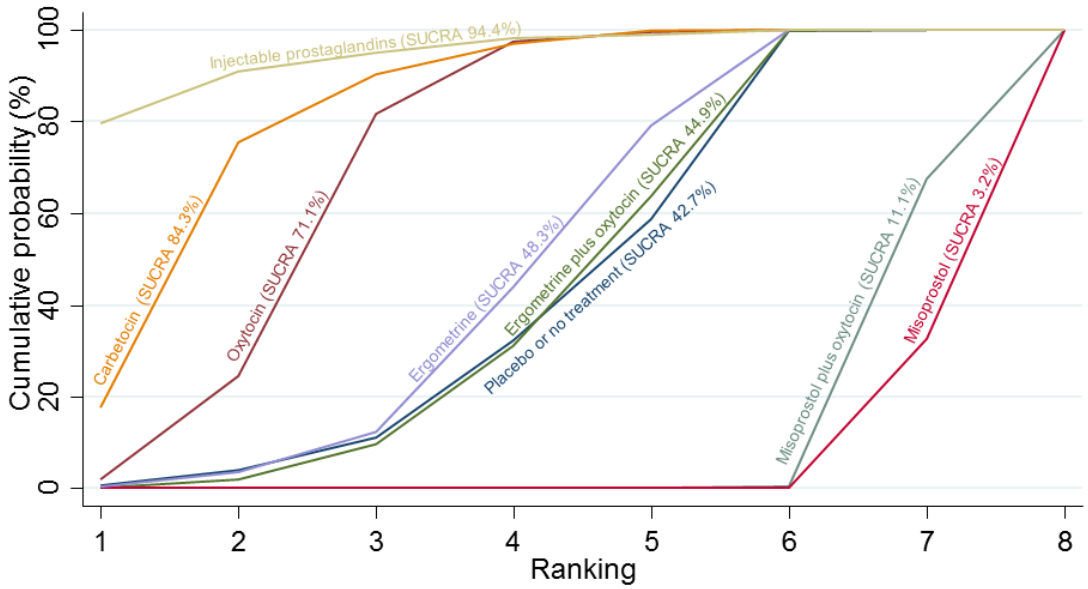


Figure 49 shows the cumulative probabilities for each agent being at each possible rank for causing shivering. The highest ranked agents are injectable prostaglandins (SUCRA 94.4%), carbetocin (SUCRA 84.3%) and oxytocin (SUCRA 71.1%). These are followed by ergometrine (SUCRA 48.3%), ergometrine plus oxytocin and placebo or no treatment (SUCRA 42.7%). The lowest ranked agents were misoprostol plus oxytocin (SUCRA 11.1%) and misoprostol (SUCRA 3.2%).

Figure 49. Cumulative rankograms comparing each of the uterotonic agents for shivering. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Abdominal pain

The network diagram for abdominal pain is presented in Figure 50. Relative effects from the network meta-analysis of 32 trials suggested that ergometrine is worse than placebo or no treatment in causing abdominal pain (Figure 51). High-certainty evidence suggests that misoprostol and misoprostol plus oxytocin make little or no difference to women's experience of abdominal pain, when compared with oxytocin. Low-certainty evidence suggests that ergometrine plus oxytocin probably make little or no difference to women's experience of abdominal pain compared with oxytocin. The effects of injectable prostaglandins and ergometrine were uncertain as the certainty of evidence was very low (Figure 51).

Figure 50. Network Diagram for abdominal pain. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

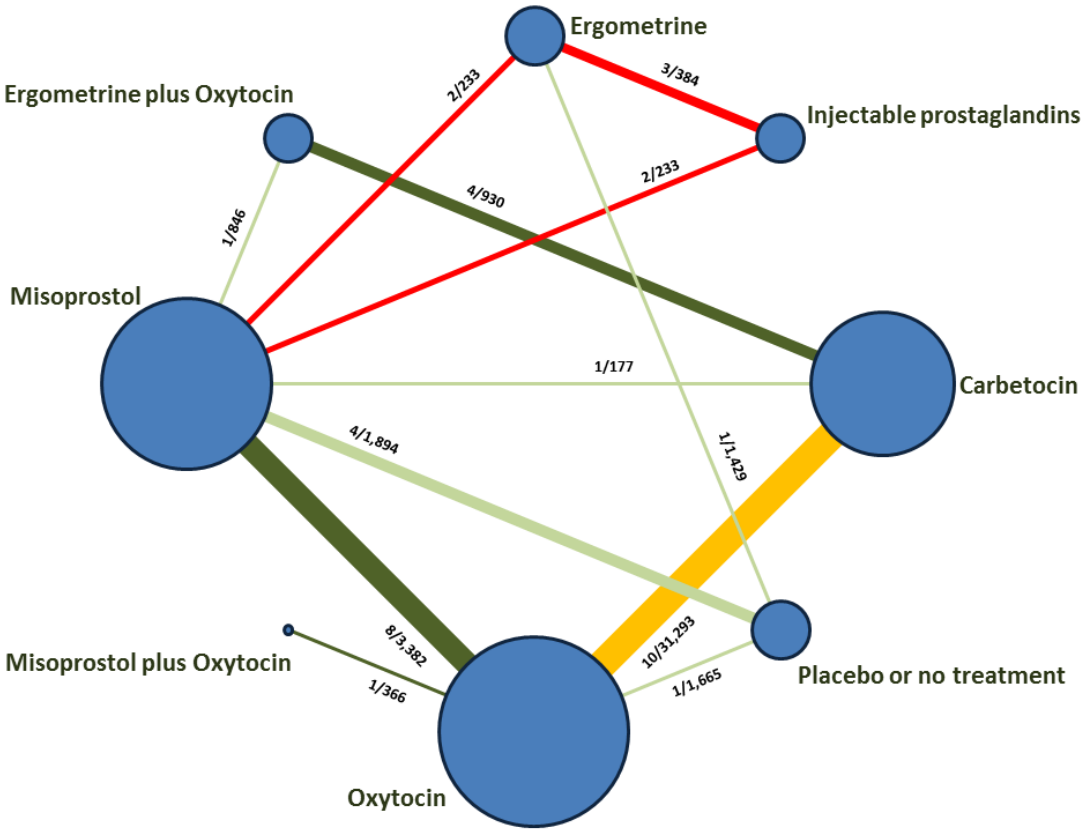


Figure 51. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for abdominal pain.

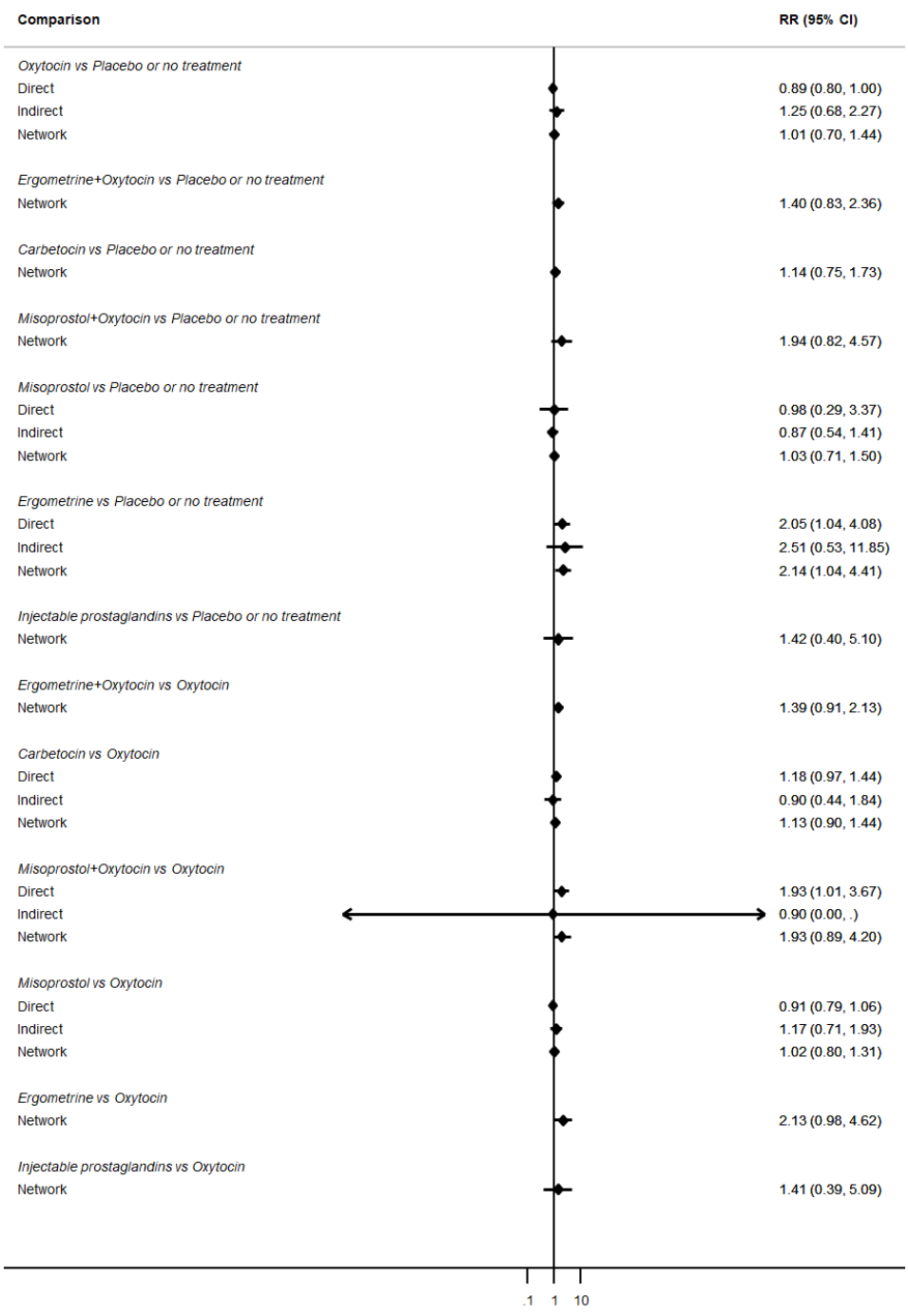
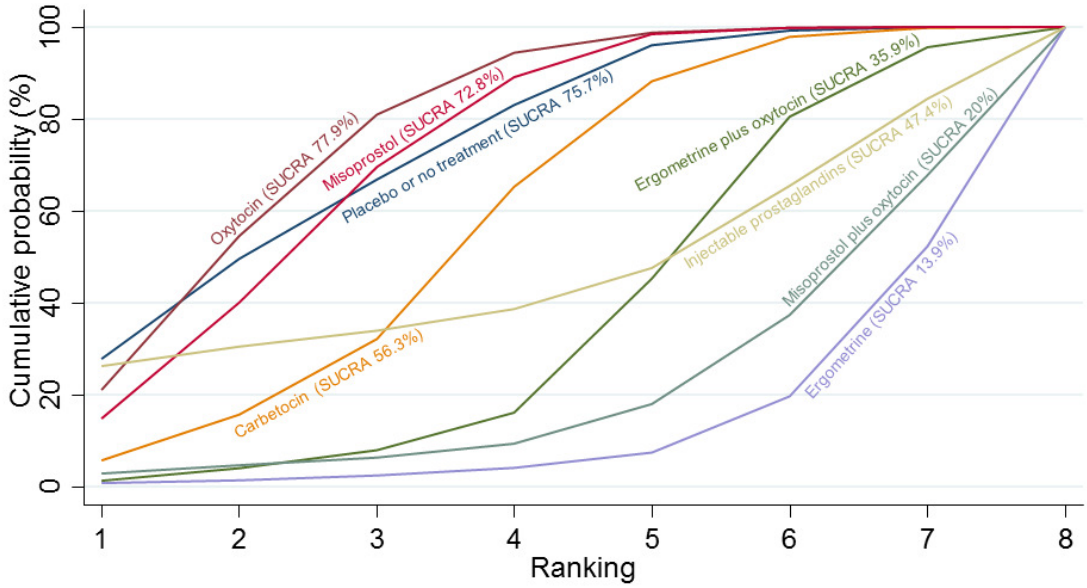


Figure 52 shows the cumulative probabilities for each agent being at each possible rank for causing abdominal pain. The highest ranked agent was oxytocin (SUCRA 77.9%), misoprostol (SUCRA 72.8%) and placebo or no treatment (SUCRA 75.7%). These were followed by carbetocin (SUCRA 56.3%), injectable prostaglandins (SUCRA 47.4%) and ergometrine plus oxytocin (SUCRA 35.9%). The lowest ranked agents are misoprostol plus oxytocin (SUCRA 20%) and ergometrine (SUCRA 13.9%).

Figure 52. Cumulative rankograms comparing each of the uterotonic agents for abdominal pain. Ranking indicates the cumulative probability of being the best agent, the second best, the third best, etc. The x axis shows the relative ranking and the y-axis the cumulative probability of each ranking.We estimate the SUrface underneath this Cumulative RAnking line (SUCRA); the larger the SUCRA the higher its rank among all available agents.



Diarrhoea

The network diagram for diarrhoea is presented in Figure 53. Relative effects from the network meta-analysis of 55 trials suggested that misoprostol, ergometrine and injectable prostaglandins are worse than placebo or no treatment in causing diarrhoea (Figure 54). High-certainty evidence shows that misoprostol (RR 2.24, 95% CI 1.64 to 3.05) and misoprostol plus oxytocin (RR 1.82, 95% CI 1.12 to 2.98) increase the likelihood of diarrhoea when compared with oxytocin (Figure 54), Moderate-certainty evidence suggests that ergometrine plus oxytocin (RR 1.80, 95% CI 1.18 to 2.75) and injectable prostaglandins (RR 23.41, 95% CI 11.03 to 49.70) probably increase the likelihood of diarrhoea, when compared with oxytocin (Figure 54). These results suggest that 11 women per 1000 given oxytocin for vaginal birth would experience diarrhoea, compared to 25 per 1000 women with misoprostol, 23 with misoprostol plus oxytocin, 20 with ergometrine plus oxytocin and 254 with injectable prostaglandins. There is also low-certainty evidence that ergometrine (RR 2.51, 95% CI 1.20 to 5.26) may increase diarrhoea (Figure 54).

Figure 53. Network Diagram for diarrhoea. The nodes represent an intervention and their size is proportional to the number of trials comparing this intervention to any other in the network. The lines connecting each pair of interventions represent a direct comparison and are drawn proportional to the number of trials making each direct comparison. Numbers on the lines represent the number of trials and participants for each comparison. The colour of the line is green for high-certainty evidence; light green for moderate-certainty evidence; orange for low-certainty evidence and red for very low-certainty evidence. Multi-arm trials contribute to more than one comparison.

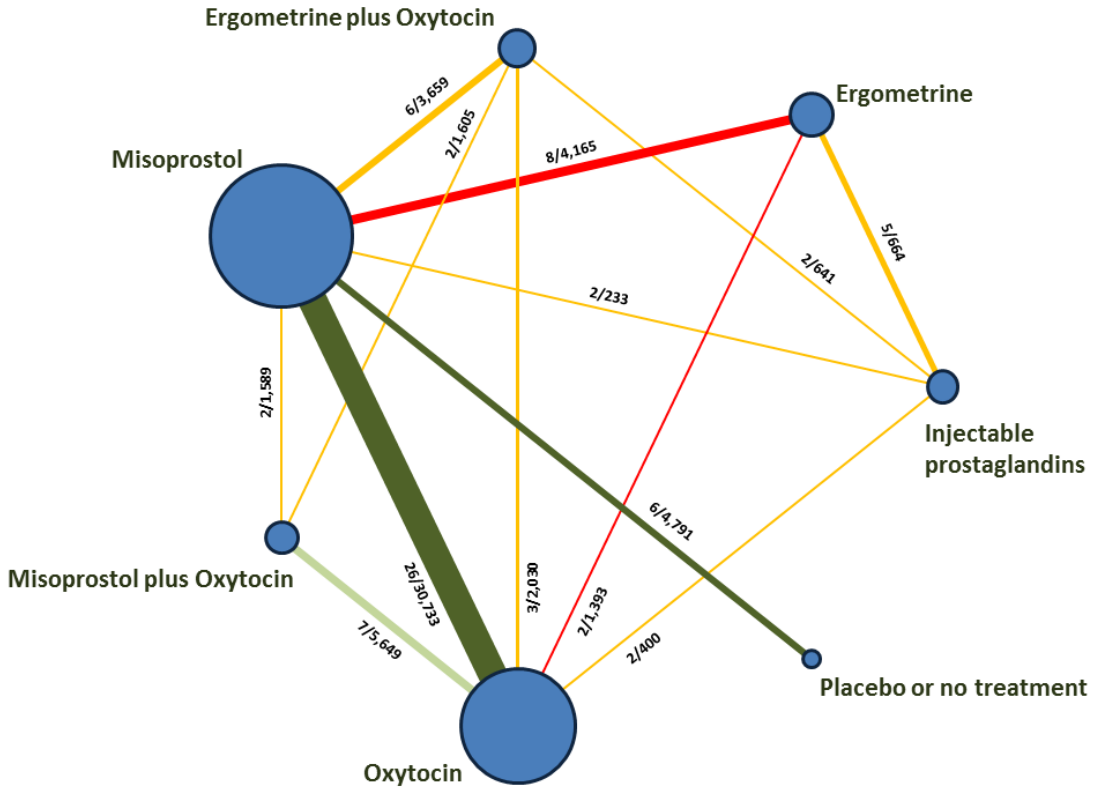


Figure 54. Forest plot with relative risk ratios and 95% CIs from pairwise, indirect and network (combining direct and indirect) analyses for diarrhoea.

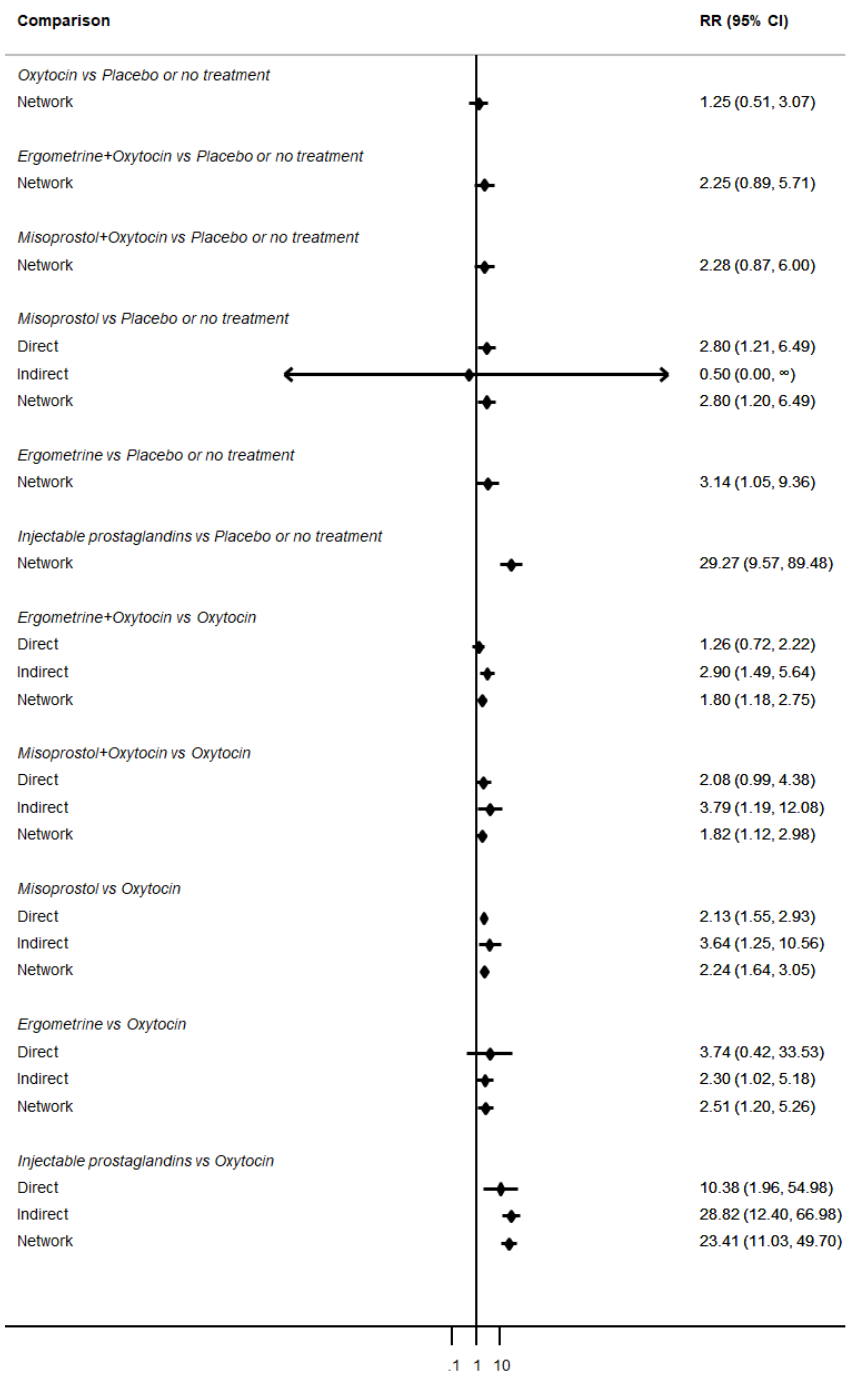


Figure 5 shows the cumulative probabilities for each agent being at each possible rank for causing diarrhoea. The highest ranked agents were placebo or no treatment (SUCRA 92.8%) and oxytocin (SUCRA 88.4%). These were followed by ergometrine plus oxytocin (SUCRA 54.1%), misoprostol plus oxytocin (SUCRA 51.8%). The lowest ranked agents are misoprostol (SUCRA 32.5%), ergometrine (SUCRA 30.3%) and injectable prostaglandins (SUCRA 0%).

Maternal sense of well-being

In total there were two trials reporting outcomes relevant to maternal sense of well-being. However, because of the heterogeneous ways maternal sense of well-being was defined in these trials a decision was made not to perform a meta-analysis.

This outcome was reported in two different ways by one trial comparing oxytocin with no treatment (Jans 2017). Low-certainty evidence suggests that the use of prophylactic oxytocin may make little or no difference to women's experience of less energy than before birth at three months postpartum (RR 1.02, 95% CI 0.93 to 1.13), or to experience of fatigue at three months postpartum (RR 0.99, 95% CI 0.95 to 1.04), Analysis 1.19.

This outcome was reported in eight different ways by another trial comparing ergometrine plus oxytocin with no treatment (Rogers 1998), Analysis 6.19. Low-certainty evidence suggests that prophylactic ergometrine plus oxytocin may make little or no difference to women's general health at six weeks postpartum when compared to no treatment (RR 0.99, 95% CI 0.71 to 1.37). Moderate-certainty evidence suggests that prophylactic ergometrine plus oxytocin probably makes little or no difference to women's exhaustion since birth when compared to no treatment (RR 0.95, 95% CI 0.79 to 1.15). Low-certainty evidence suggests that prophylactic ergometrine plus oxytocin may make little or no difference to women's exhaustion at six weeks postpartum when compared to no treatment (RR 0.95, 95% CI 0.74 to 1.21). Moderate-certainty evidence suggests that prophylactic ergometrine plus oxytocin probably makes little or no difference to women's blues at six weeks postpartum when compared to no treatment (RR 0.93, 95% CI 0.83 to 1.04). Low-certainty evidence suggests that prophylactic ergometrine plus oxytocin may make little or no difference to women experiencing depression at six weeks postpartum when compared to no treatment (RR 1.22, 95% CI 0.84 to 1.78). Low-certainty evidence suggests that prophylactic ergometrine plus oxytocin may make little or no difference to women looking for help for depression at six weeks postpartum when compared to no treatment (RR 1.05, 95% CI from 0.82 to 1.35). It is uncertain whether prophylactic ergometrine plus oxytocin reduces admissions to hospital for depression at six weeks postpartum when compared to no treatment because the certainty of this evidence is very low (RR 3.06, 95% CI 0.12 to 75.06). Moderate-certainty evidence suggests that prophylactic ergometrine plus oxytocin probably makes little or no difference to women reporting health problems at six weeks postpartum when compared to no treatment (RR 0.95, 95% CI 0.90 to 1.01).

Maternal satisfaction

In total, there were five trials reporting outcomes relevant to maternal satisfaction. However, because of the heterogeneous ways maternal satisfaction was defined in these trials a decision was made not to perform a meta-analysis.

This outcome was reported in three different ways by one trial comparing oxytocin with no treatment (Jangsten 2011). Moderate-certainty evidence suggests that the use of prophylactic oxytocin may make little or no difference to women's perception of whether management of the birth positively influenced the childbirth experience for mothers (RR 1.01, 95% CI 0.89 to 1.15); or made little or no difference to the mother's childbirth experience (RR 1.02, 95% CI 0.90 to 1.15). Low-certainty evidence suggests that the use of prophylactic oxytocin may make little or no difference to the extent to which women perceive that management of the birth negatively influenced the childbirth experience for mothers (RR 0.73, 95% CI 0.47 to 1.13), Analysis 1.20.

This outcome was reported in two different ways by one trial comparing ergometrine plus oxytocin with no treatment (Rogers 1998). Moderate-certainty evidence suggests that prophylactic ergometrine plus oxytocin probably makes little or no difference to satisfaction with third-stage management when compared to no treatment (RR 1.03, 95% CI from 1.00 to 1.05). Moderate-certainty evidence suggests that prophylactic ergometrine plus oxytocin probably decreased women feeling in control during third stage when compared to no treatment (RR 0.95, 95% CI 0.91 to 0.99), Analysis 6.20.

This outcome was reported in four different ways by one trial comparing misoprostol with oxytocin (Diop 2016). Moderate-certainty evidence suggests that prophylactic misoprostol, when compared to oxytocin, probably makes little or no difference to women being satisfied or very satisfied with the uterotonic agent they received (RR 1.01, 95% CI 1.00 to 1.02), or that women would make a complaint about, or have problems with, the uterotonic agent they received (RR 0.36, 95% CI 0.20 to 0.64), or that women would take the specific uterotonic agent again after subsequent deliveries (RR 1.01, 95% CI 1.00 to 1.02), or that women would recommend the specific uterotonic agent to a friend (RR 1.01, 95% CI 1.00 to 1.02), Analysis 8.20.

This outcome was reported by one trial comparing ergometrine plus oxytocin with misoprostol using an eight-item Client Satisfaction Questionnaire (Ng 2007). Moderate-certainty evidence suggests that prophylactic ergometrine plus oxytocin, when compared

to misoprostol, probably makes little or no difference to women being satisfied with the uterotonic agent they received (MD 0.6 lower, 95% CI 1.22 lower to 0.02 higher).

Subgroup analyses

We carried out subgroup analyses for PPH ≥ 500 mL and PPH ≥ 1000 mL by mode of birth (caesarean versus vaginal birth), setting (hospital versus community), risk of PPH (high versus low risk for PPH), dose of misoprostol (≥ 600 mcg versus < 600 mcg), and regimen of oxytocin (bolus versus bolus plus infusion versus infusion only). The network diagrams for all subgroups are available from Appendix 2. Relative effects and cumulative probabilities for each agent being at each possible rank from the network meta-analysis for each subgroup are also available from Appendix 2. Subgroup analyses did not reveal important subgroup differences for any of the subgroups.

Sensitivity analyses

We carried out pre-specified sensitivity analyses by restricting our analyses to studies at low risk of bias, studies at low risk of bias in terms of funding sources, to studies that used an objective method of measuring blood loss and large trials with more than 400 participants. Details of these analyses are available from Appendix 2. Sensitivity analyses were also performed according to the choice of relative effect measure (risk ratio (RR) versus odds ratio (OR)) and the statistical model (fixed-effect versus random-effects model). Further sensitivity analyses identified during the review process were performed by removing trials published earlier than 1990, cluster trials, removing trials with a high level of missing data and removing trials where participants were also randomised to co-agents such as uterine massage or early controlled cord traction, or both. The sensitivity analyses show that the overall results are not affected by the abovementioned criteria or decisions.

ADDITIONAL SUMMARY OF FINDINGS [*Explanation*]

Patient or population: women in the third stage of labour
Interventions: carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin
Comparison (reference): oxytocin
Outcome: PPH ≥ 1000 mL
Setting: hospital or community setting

Uterotonic agent(s)	Direct evidence		Indirect evidence		NMA evidence		Anticipated absolute effects for NMA estimate		
	RR (95% CI)	Certainty	RR (95% CI)	Certainty	RR (95% CI)	Certainty	Risk with oxytocin	Risk with intervention (other uterotonics)	Risk difference with intervention
Carbetocin	0.73 (0.45 to 1.19)	⊕⊕◯◯ LOW [a]	0.30 (0.13 to 0.72)	⊕⊕◯◯ LOW [b]	0.87 (0.62 to 1.21)	⊕◯◯◯ VERY LOW [c]	37 per 1000	32 per 1000	5 fewer per 1000 (from 14 fewer to 8 more)
							Vaginal birth: 30 per 1000	Vaginal birth: 26 per 1000	Vaginal birth: 4 fewer per 1000 (11 fewer to 6 more)
							Caesarean birth: 33 per 1000	Caesarean birth: 116 per 1000	Caesarean birth: 17 fewer per 1000 (from 51 fewer to 28 more)
Misoprostol	1.26 (1.11 to 1.43)	⊕⊕⊕⊕ HIGH	1.23 (0.92 to 1.64)	⊕⊕⊕◯ MODERATE [d]	1.19 (1.01 to 1.42)	⊕⊕⊕⊕ HIGH [e]	37 per 1000	44 per 1000	7 more per 1000 (0 fewer to 16 more)

							Vaginal birth: 30 per 1000	Vaginal birth: 36 per 1000	Vaginal birth: 6 more per 1000 (0 fewer to 13 more)
							Caesarean birth: 133 per 1000	Caesarean birth: 158 per 1000	Caesarean birth: 25 more per 1000 (1 more to 56 more)
Injectable prostaglandin	1.43 (0.20 to 10.31)	⊕◯◯◯ VERY LOW [f]	0.74 (0.31 to 1.72)	⊕◯◯◯ VERY LOW [g]	0.88 (0.41 to 1.89)	⊕◯◯◯ VERY LOW [h]	37 per 1000	33 per 1000	4 fewer per 1000 (22 fewer to 33 more)
							Vaginal birth: 30 per 1000	Vaginal birth: 27 per 1000	Vaginal birth: 3 fewer per 1000 (18 fewer to 27 more)
							Caesarean birth: 133 per 1000	Caesarean birth: 118 per 1000	Caesarean birth: 15 fewer per 1000
Ergometrine	1.30 (0.52 to 3.27)	⊕◯◯◯ VERY LOW [f]	0.61 (0.22 to 1.67)	⊕⊕◯◯ LOW [i]	0.94 (0.48 to 1.84)	⊕⊕◯◯ LOW [j]	37 per 1000	35 per 1000	2 fewer per 1000 (19 fewer to 31 more)
							Vaginal birth: 30 per 1000	Vaginal birth: 28 fewer per 1000	Vaginal birth: 2 fewer per 1000 (16 fewer to 25 more)

							Caesarean birth: 133 per 1000	Caesarean birth: 122 per 1000	Caesarean birth: 8 fewer per 1000 (69 fewer to 112 more)
Ergometrine plus oxytocin	0.73 (0.57 to 0.93)	⊕⊕⊕⊕ HIGH	1.07 (0.75 to 1.54)	⊕⊕⊕◯ MODERATE [k]	0.83 (0.66 to 1.03)	⊕⊕⊕⊕ HIGH [e]	37 per 1000	31 per 1000	6 fewer per 1000 (13 fewer to 1 more)
							Vaginal birth: 30 per 1000	Vaginal birth: 25 per 1000	Vaginal birth: 5 fewer per 1000 (10 fewer to 1 more)
							Caesarean birth: 133 per 1000	Caesarean birth: 124 per 1000	Caesarean birth: 9 fewer per 1000 (45 fewer to 4 more)
Misoprostol plus oxytocin	0.87 (0.69 to 1.09)	⊕⊕⊕◯ MODERATE [l]	1.17 (0.47 to 2.86)	⊕⊕⊕⊕ HIGH	0.88 (0.70 to 1.11)	⊕⊕⊕⊕ HIGH [e]	37 per 1000	31 per 1000	6 fewer per 1000 (13 fewer to 1 more)
							Vaginal birth: 30 per 1000	Vaginal birth: 25 per 1000	Vaginal birth: 5 fewer per 1000 (10 fewer to 1 more)
							Caesarean birth: 133 per 1000	Caesarean birth: 124 per 1000	Caesarean birth: 9 fewer per 1000 (45 fewer to 4 more)

The assumed risks in the oxytocin group are based on weighted means of baseline risks from the studies with oxytocin groups in the network meta-analysis. **The corresponding risks in the carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin groups** (and their 95% confidence interval) are based on the assumed risk in the oxytocin group and the **relative effect** of individual uterotonic when compared with oxytocin (and its 95% CI) derived from the network meta-analysis

* No included studies or there are no event in included studies to estimate the baseline risk

** Absolute risk with uterotonic cannot be estimated in the absence of absolute risk with oxytocin

*** Risk difference cannot be estimated in the absence of absolute risks with intervention and oxytocin

CI: Confidence interval; **RR:** Risk ratio.

GRADE Working Group grades of evidence

High certainty: We are very confident that the true effect lies close to that of the estimate of the effect

Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

[a] Direct evidence downgraded -2 due to serious imprecision and strong suspicion of publication bias

[b] Indirect evidence downgraded -2 due to very serious imprecision

[c] Network evidence downgraded -2 due to low certainty direct and indirect evidence, and -1 due to incoherence between the direct and indirect estimates (no intransitivity, network estimate remains imprecise)

[d] Indirect evidence downgraded -1 due to serious imprecision

[e] Network evidence not downgraded due to high certainty indirect evidence (no intransitivity, incoherence, or imprecision)

[f] Direct evidence downgraded -3 due to multiple limitations in study design and very serious imprecision

[g] Indirect evidence downgraded -3 due to multiple limitations in study design and very serious imprecision

[h] Network evidence downgraded -3 due to very low certainty direct and indirect evidence (no intransitivity or incoherence, network estimate remains imprecise)

[i] Indirect evidence downgraded -2 due to multiple limitations in study design and serious imprecision

[j] Network evidence downgraded -2 due to low certainty indirect evidence (no intransitivity or incoherence, network estimate remains imprecise)

[k] Indirect evidence downgraded -1 due to multiple limitations in study design

[l] Direct evidence downgraded -1 due to serious imprecision

Patient or population: women in the third stage of labour
Interventions: carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin
Comparison (reference): oxytocin
Outcome: use of additional uterotonics
Setting: hospital or community setting

Uterotonic agent(s)	Direct evidence		Indirect evidence		NMA evidence		Anticipated absolute effects for NMA estimate		
	RR (95% CI)	Certainty	RR (95% CI)	Certainty	RR (95% CI)	Certainty	Risk with oxytocin	Risk with intervention (other uterotonics)	Risk difference with intervention
Carbetocin	0.48 (0.34 to 0.68)	⊕⊕◯◯ LOW [a]	0.35 (0.22 to 0.57)	⊕⊕◯◯ LOW [b]	0.45 (0.34 to 0.59)	⊕⊕◯◯ LOW [c]	135 per 1000	61 per 1000	74 fewer per 1000 (89 fewer to 55 fewer)
							Vaginal birth: 116 per 1000	Vaginal birth: 52 per 1000	Vaginal birth: 64 fewer per 1000 (77 fewer to 48 fewer)
							Caesarean birth: 304 per 1000	Caesarean birth: 137 per 1000	Caesarean birth: 167 fewer per 1000 (201 fewer to 125 fewer)
Misoprostol	1.01 (0.85 to 1.20)	⊕⊕◯◯ LOW [a]	1.18 (0.81 to 1.73)	⊕⊕◯◯ LOW [b]	1.04 (0.88 to 1.24)	⊕⊕◯◯ LOW c	135 per 1000	140 per 1000	5 more per 1000 (16 fewer to 32 more)
							Vaginal birth: 116 per 1000	Vaginal birth: 121 per 1000	Vaginal birth: 5 more per 1000 (14 fewer to 28 more)

							Caesarean birth: 304 per 1000	Caesarean birth: 316 per 1000	Caesarean birth: 12 more per 1000 (36 fewer to 73 more
Injectable prostaglandin	0.29 (0.09 to 0.94)	⊕⊕◯◯ LOW [d]	0.78 (0.38 to 1.59)	⊕⊕◯◯ LOW [e]	0.55 (0.31 to 0.96)	⊕⊕◯◯ LOW [c]	135 per 1000	74 per 1000	61 fewer per 1000 (93 fewer to 5 fewer)
							Vaginal birth: 116 per 1000	Vaginal birth: 64 per 1000	Vaginal birth: 52 fewer per 1000 (80 fewer to 5 fewer)
							Caesarean birth: 304 per 1000	Caesarean birth: 167 per 1000	Caesarean birth: 137 fewer per 1000 (210 fewer to 12 fewer)
Ergometrine	1.46 (0.61 to 3.48)	⊕◯◯◯ VERY LOW [f]	0.83 (0.55 to 1.26)	⊕◯◯◯ VERY LOW [g]	0.97 (0.69 to 1.36)	⊕◯◯◯ VERY LOW [h]	135 per 1000	131 per 1000	4 fewer per 1000 (42 fewer to 49 more)
							Vaginal birth: 116 per 1000	Vaginal birth: 113 per 1000	Vaginal birth: 3 fewer per 1000 (36 fewer to 42 more)
							Caesarean birth: 304 per 1000	Caesarean birth: 295 per 1000	Caesarean birth: 9 fewer per 1000 (94 fewer to 109 more)

Ergometrine plus oxytocin	0.79 (0.59 to 1.07)	⊕◯◯◯ VERY LOW [f]	0.57 (0.40 to 0.81)	⊕⊕◯◯ LOW [b]	0.65 (0.50 to 0.85)	⊕⊕◯◯ LOW [c]	135 per 1000	89 per 1000	46 fewer per 1000 (66 fewer to 20 fewer)
							Vaginal birth: 116 per 1000	Vaginal birth: 77 per 1000	Vaginal birth: 39 fewer per 1000 (57 fewer to 17 fewer)
							Caesarean birth: 304 per 1000	Caesarean birth: 201 per 1000	1Caesarean birth: 03 fewer per 1000 (149 fewer to 46 fewer)
Misoprostol plus oxytocin	0.54 (0.44 to 0.67)	⊕⊕⊕⊕ HIGH	0.68 (0.31 to 1.51)	⊕⊕◯◯ LOW [b]	0.56 (0.42 to 0.73)	⊕⊕⊕⊕ HIGH [i]	135 per 1000	77 per 1000	58 fewer per 1000 (76 fewer to 35 fewer)
							Vaginal birth: 116 per 1000	Vaginal birth: 66 per 1000	Vaginal birth: 50 fewer per 1000 (65 fewer to 30 fewer)
							Caesarean birth: 304 per 1000	Caesarean birth: 173 per 1000	Caesarean birth: 131 fewer per 1000 (170 fewer to 79 fewer)

The assumed risks in the oxytocin group are based on weighted means of baseline risks from the studies with oxytocin groups in the network meta-analysis.**The corresponding risks in the Carbetocin, Misoprostol, Injectable prostaglandins, Ergometrine, Ergometrine plus oxytocin (Syntometrine ®), Misoprostol plus oxytocin groups** (and their 95% confidence interval) are based on the assumed risk in the oxytocin group and the **relative effect** of individual uterotonic when compared with oxytocin (and its 95% CI) derived from the network meta-analysis

* No included studies or there are no event in included studies to estimate the baseline risk

** Absolute risk with uterotonic cannot be estimated in the absence of absolute risk with oxytocin
*** Risk difference cannot be estimated in the absence of absolute risks with intervention and oxytocin
CI: Confidence interval; **RR:** Risk ratio.

GRADE Working Group grades of evidence
High certainty: We are very confident that the true effect lies close to that of the estimate of the effect
Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

[a] Direct evidence downgraded -2 due to multiple limitations in study design and severe unexplained statistical heterogeneity
[b] Indirect evidence downgraded -2 due to multiple limitations in study design and severe unexplained statistical heterogeneity
[c] Network evidence downgraded -2 due to low certainty direct and indirect evidence (no intransitivity, incoherence or serious imprecision)
[d] Direct evidence downgraded -2 due to multiple crucial limitations in study design
[e] Indirect evidence downgraded -2 due to multiple limitations in study design, severe unexplained statistical heterogeneity and serious imprecision
[f] Direct evidence downgraded -3 due to multiple limitations in study design, severe unexplained statistical heterogeneity and serious imprecision
[g] Indirect evidence downgraded -3 due to multiple limitations in study design, severe unexplained statistical heterogeneity and serious imprecision
[h] Network evidence downgraded -3 due to very low certainty direct and indirect evidence (no intransitivity or incoherence, network estimate remains imprecise)
[i] Network evidence not downgraded due to high certainty direct evidence (no intransitivity, incoherence, or imprecision)

Patient or population: women in the third stage of labour
Interventions: carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin
Comparison (reference): oxytocin
Outcome: blood transfusion
Setting: hospital or community setting

Uterotonic agent(s)	Direct evidence		Indirect evidence		NMA evidence		Anticipated absolute effects for NMA estimate		
	RR (95% CI)	Certainty	RR (95% CI)	Certainty	RR (95% CI)	Certainty	Risk with oxytocin	Risk with intervention (other uterotonics)	Risk difference with intervention
Carbetocin	0.68 (0.38 to 1.22)	⊕⊕⊕◯ MODERATE [a]	0.62 (0.21 to 1.85)	⊕⊕◯◯ LOW [b]	0.81 (0.49 to 1.32)	⊕⊕⊕◯ MODERATE [c]	22 per 1000	18 per 1000	4 fewer per 1000 (11 fewer to 7 more)
							Vaginal birth: 15 per 1000	Vaginal birth: 12 per 1000	Vaginal birth: 3 fewer per 1000 (5 fewer to 4 more)
							Caesarean birth: 81 per 1000	Caesarean birth:66 per 1000	Caesarean birth:15 fewer per 1000 (41 fewer to 26 more)
Misoprostol	0.81 (0.65 to 1.00)	⊕⊕⊕◯ MODERATE [a]	1.02 (0.59 to 1.77)	⊕⊕◯◯ LOW [d]	0.88 (0.68 to 1.13)	⊕⊕⊕◯ MODERATE [c]	22 per 1000	19 per 1000	3 fewer per 1000 (7 fewer to 3 more)

							Vaginal birth: 15 per 1000	Vaginal birth: 13 per 1000	Vaginal birth: 2 fewer per 1000 (5 fewer to 2 more)
							Caesarean birth: 81 per 1000	Caesarean birth: 71 per 1000	Caesarean birth: 10 fewer per 1000 (26 fewer to 11 more)
Injectable prostaglandin	1.01 (0.04 to 23.65)	⊕◯◯◯ VERY LOW [e]	0.49 (0.16 to 1.52)	⊕◯◯◯ VERY LOW [f]	0.66 (0.25 to 1.72)	⊕◯◯◯ VERY LOW [g]	22 per 1000	15 per 1000	7 fewer per 1000 (17 fewer to 16 more)
							Vaginal birth: 15 per 1000	Vaginal birth: 10 per 1000	Vaginal birth: 5 fewer per 1000 (11 fewer to 11 more)
							Caesarean birth: 81 per 1000	Caesarean birth: 56 per 1000	Caesarean birth: 28 fewer per 1000 (61 fewer to 58 more)
Ergometrine	1.44 (0.20 to 10.23)	⊕◯◯◯ VERY LOW [h]	1.01 (0.38 to 2.68)	⊕⊕◯◯ LOW [i]	1.11 (0.54 to 2.28)	⊕⊕◯◯ LOW [j]	22 per 1000	24 per 1000	2 more per 1000 (10 fewer to 28 more)
							Vaginal birth: 15 per 1000	Vaginal birth: 17 per 1000	Vaginal birth: 2 more per 1000 (7 fewer to 19 more)

							Cae-sarean birth: 81 per 1000	Cae-sarean birth: 90 per 1000	Cae-sarean birth: 9 more per 1000 (37 fewer to 104 more)
Ergometrine plus oxytocin	0.88 (0.53 to 1.44)	⊕⊕◯◯ LOW [k]	0.64 (0.41 to 1.00)	⊕⊕◯◯ LOW [i]	0.77 (0.58 to 1.03)	⊕⊕◯◯ LOW [j]	22 per 1000	17 per 1000	5 fewer per 1000 (9 fewer to 1 more)
							Vaginal birth: 15 per 1000	Vaginal birth: 12 per 1000	Vaginal birth: 3 fewer per 1000 (6 fewer to 0 fewer)
							Cae-sarean birth: 81 per 1000	Cae-sarean birth: 63 per 1000	Cae-sarean birth: 18 fewer per 1000 (33 fewer to 2 more)
Misoprostol plus oxytocin	0.50 (0.37 to 0.67)	⊕⊕◯◯ LOW [l]	0.77 (0.27 to 2.26)	⊕⊕⊕◯ MODERATE [m]	0.51 (0.37 to 0.70)	⊕⊕⊕◯ MODERATE [c]	22 per 1000	11 per 1000	11 fewer per 1000 (14 fewer to 7 fewer)
							Vaginal birth: 15 per 1000	Vaginal birth: 8 per 1000	Vaginal birth: 7 fewer per 1000 (9 fewer to 5 fewer)
							Cae-sarean birth: 81 per 1000	Cae-sarean birth: 42 per 1000	Cae-sarean birth: 39 fewer per 1000 (50 fewer to 24 fewer)

The assumed risks in the oxytocin group are based on weighted means of baseline risks from the studies with oxytocin groups in the network meta-analysis. **The corresponding risks in the carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin groups** (and their 95% confidence interval) are based on the assumed risk in the oxytocin group and the **relative effect** of individual uterotonic when compared with oxytocin (and its 95% CI) derived from the network meta-analysis

* No included studies or there are no event in included studies to estimate the baseline risk

** Absolute risk with uterotonic cannot be estimated in the absence of absolute risk with oxytocin

*** Risk difference cannot be estimated in the absence of absolute risks with intervention and oxytocin

CI: Confidence interval; **RR:** Risk ratio.

GRADE Working Group grades of evidence

High certainty: We are very confident that the true effect lies close to that of the estimate of the effect

Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

[a] Direct evidence downgraded -1 due to serious imprecision

[b] Indirect evidence downgraded -2 due to very serious imprecision

[c] Network evidence downgraded -1 due to moderate certainty direct evidence (no intransitivity or incoherence, network estimate remains imprecise)

[d] Indirect evidence downgraded -2 due to multiple limitations in study design and strong suspicion of publication bias

[e] Direct evidence downgraded -3 due to multiple limitations in study design and very serious imprecision

[f] Indirect evidence downgraded -3 due to multiple crucial limitations in study design and very serious imprecision

[g] Network evidence downgraded -3 due to very low certainty direct and indirect evidence (no intransitivity or incoherence, network estimate remains imprecise)

[h] Direct evidence downgraded -3 due to multiple limitations in study design, severe unexplained statistical heterogeneity and very serious imprecision

[i] Indirect evidence downgraded -2 due to multiple limitations in study design and serious imprecision

[j] Network evidence downgraded -2 due to low certainty indirect evidence (no intransitivity or incoherence, network estimate remains imprecise)

[k] Direct evidence downgraded -2 due to multiple limitations in study design and serious imprecision

[l] Direct evidence downgraded -2 due to multiple limitations in study design and strong suspicion of publication bias

[m] Indirect evidence downgraded -1 due to multiple limitations in study design and serious imprecision

Patient or population: women in the third stage of labour
Interventions: carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin
Comparison (reference): oxytocin
Outcome: vomiting
Setting: hospital or community setting

Uterotonic agent(s)	Direct evidence		Indirect evidence		NMA evidence		Anticipated absolute effects for NMA estimate		
	RR (95% CI)	Certainty	RR (95% CI)	Certainty	RR (95% CI)	Certainty	Risk with oxytocin	Risk with intervention (other uterotonics)	Risk difference with intervention
Carbetocin	0.90 (0.53 to 1.50)	⊕⊕⊕◯ MODERATE [a]	1.00 (0.51 to 1.95)	⊕⊕◯◯ LOW [b]	0.93 (0.64 to 1.35)	⊕⊕⊕◯ MODERATE [c]	28 per 1000	26 per 1000	2 fewer per 1000 (10 fewer to 10 more)
							Vaginal birth: 13 per 1000	Vaginal birth: 12 per 1000	Vaginal birth: 1 fewer per 1000 (5 fewer to 5 more)
							Caesarean birth: 97 per 1000	Caesarean birth: 91 per 1000	Caesarean birth: 6 fewer per 1000 (34 fewer to 35 more)
Misoprostol	1.51 (1.19 to 1.91)	⊕⊕⊕⊕ HIGH	2.73 (1.66 to 4.50)	⊕⊕◯◯ LOW [d]	1.63 (1.25 to 2.14)	⊕⊕⊕◯ MODERATE [e]	28 per 1000	46 per 1000	18 more per 1000 (7 more to 32 more)

							Vaginal birth: 13 per 1000	Vaginal birth: 21 per 1000	Vaginal birth: 8 more per 1000 (3 more to 15 more)
							Caesarean birth: 97 per 1000	Caesarean birth: 158 per 1000	Caesarean birth: 61 more per 1000 (24 more to 111 more)
Injectable prostaglandin	2.48 (0.57 to 10.73)	⊕◯◯◯ VERY LOW [f]	4.07 (1.93 to 8.60)	⊕◯◯◯ VERY LOW [g]	3.76 (1.90 to 7.42)	⊕⊕◯◯ LOW [h]	28 per 1000	105 per 1000	77 more per 1000 (25 more to 180 more)
							Vaginal birth: 13 per 1000	Vaginal birth: 49 per 1000	Vaginal birth: 36 more per 1000 (12 more to 83 more)
							Caesarean birth: 97 per 1000	Caesarean birth: 365 per 1000	Caesarean birth: 268 more per 1000 (87 more to 623 more)
Ergometrine	3.83 (1.10 to 13.28)	⊕⊕◯◯ LOW [i]	1.83 (1.18 to 2.84)	⊕⊕◯◯ LOW [j]	2.36 (1.56 to 3.55)	⊕⊕⊕◯ MODERATE [k]	28 per 1000	66 per 1000	38 more per 1000 (16 more to 71 more)

							Vaginal birth: 13 per 1000	Vaginal birth: 31 per 1000	Vaginal birth: 18 more per 1000 (7 more to 33 more)
							Caesarean birth: 97 per 1000	Caesarean birth: 229 per 1000	Caesarean birth: 132 more per 1000 (54 more to 247 more)
Ergometrine plus oxytocin	3.05 (1.76 to 5.29)	⊕⊕⊕◯ MODERATE [l]	2.77 (1.75 to 4.38)	⊕⊕◯◯ LOW [d]	2.93 (2.08 to 4.13)	⊕⊕⊕◯ MODERATE [m]	28 per 1000	82 per 1000	54 more per 1000 (30 more to 88 more)
							Vaginal birth: 13 per 1000	Vaginal birth: 38 per 1000	Vaginal birth: 25 more per 1000 (14 more to 41 more)
							Caesarean birth: 97 per 1000	Caesarean birth: 284 per 1000	Caesarean birth: 187 more per 1000 (105 more to 304 more)
Misoprostol plus oxytocin	2.24 (1.52 to 3.31)	⊕⊕⊕⊕ HIGH	1.48 (0.52 to 4.27)	⊕◯◯◯ VERY LOW [g]	2.11 (1.39 to 3.18)	⊕⊕⊕⊕ HIGH [n]	28 per 1000	59 per 1000	31 more per 1000 (11 more to 61 more)

	Vaginal birth: 13 per 1000	Vaginal birth: 27 per 1000	Vaginal birth: 14 more per 1000 (5 more to 28 more)
	Caesarean birth: 97 per 1000	Caesarean birth: 205 per 1000	Caesarean birth: 108 more per 1000 (38 more to 211 more)

The assumed risks in the oxytocin group are based on weighted means of baseline risks from the studies with oxytocin groups in the network meta-analysis.**The corresponding risks in the carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin groups** (and their 95% confidence interval) are based on the assumed risk in the oxytocin group and the **relative effect** of individual uterotonic when compared with oxytocin (and its 95% CI) derived from the network meta-analysis

* No included studies or there are no event in included studies to estimate the baseline risk

** Absolute risk with uterotonic cannot be estimated in the absence of absolute risk with oxytocin

***Risk difference cannot be estimated in the absence of absolute risks with intervention and oxytocin

CI: Confidence interval; **RR:** Risk ratio.

GRADE Working Group grades of evidence

High certainty: We are very confident that the true effect lies close to that of the estimate of the effect

Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

[a] Direct evidence downgraded -1 due to serious imprecision

[b] Indirect evidence downgraded -2 due to very serious imprecision

[c] Network evidence downgraded -1 due to moderate certainty direct evidence (no intransitivity or incoherence, network estimate remains imprecise)

[d] Indirect evidence downgraded -2 due to multiple crucial limitations in study design and serious imprecision

[e] Network evidence not initially downgraded given high certainty direct evidence; however, downgraded -1 due to incoherence between the direct and indirect estimates (no intransitivity or imprecision)

[f] Direct evidence downgraded -3 due to multiple limitations in study design and very serious imprecision

[g] Indirect evidence downgraded -3 due to multiple limitations in study design and very serious imprecision

[h] Network evidence initially downgraded -3 due to very low certainty direct and indirect evidence, however upgraded +1 due to precision of network estimate (when direct and indirect were both imprecise; no intransitivity or incoherence)
[i] Direct evidence downgraded -2 due to multiple crucial limitations in study design
[j] Indirect evidence downgraded -2 due to multiple limitations in study design and serious imprecision
[k] Network evidence initially downgraded -2 due to low certainty direct and indirect evidence, however upgraded +1 due to precision of network estimate (when direct and indirect were both imprecise; no intransitivity or incoherence)
[l] Direct evidence downgraded -1 due to multiple limitations in study design
[m] Network evidence downgraded -1 due to moderate certainty direct evidence (no intransitivity, incoherence, or serious imprecision)
[n] Network evidence not downgraded due to high certainty direct evidence (no intransitivity, incoherence, or serious imprecision)

Patient or population: women in the third stage of labour
Interventions: carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin
Comparison (reference): oxytocin
Outcome: hypertension
Setting: hospital or community setting

Uterotonic agent(s)	Direct evidence		Indirect evidence		NMA evidence		Anticipated absolute effects for NMA estimate		
	RR (95% CI)	Certainty	RR (95% CI)	Certainty	RR (95% CI)	Certainty	Risk with oxytocin	Risk with intervention (other uterotonics)	Risk difference with intervention
Carbetocin	Not reported by included studies	–	1.24 (0.28 to 5.56)	⊕◯◯◯ VERY LOW [a]	1.24 (0.28 to 5.56)	⊕◯◯◯ VERY LOW [b]	82 per 1000	102 per 1000	20 more per 1000 (59 fewer to 374 more)
							Vaginal birth: 76 per 1000	Vaginal birth: 94 per 1000	Vaginal birth: 18 more per 1000 (55 fewer to 347 more)
							Caesarean birth: 167 per 1000	Caesarean birth: 207 per 1000	Caesarean birth: 40 more per 1000 (120 fewer to 762 more)
Misoprostol	3.64 (0.60 to 22.27)	⊕◯◯◯ VERY LOW [c]	1.01 (0.28 to 3.65)	⊕⊕◯◯ LOW [d]	1.50 (0.49 to 4.61)	⊕⊕◯◯ LOW [e]	82 per 1000	123 per 1000	41 more per 1000 (42 fewer to 296 more)

							Vaginal birth: 76 per 1000	Vaginal birth: 114 per 1000	Vaginal birth: 38 more per 1000 (39 fewer to 274 more)
							Caesarean birth: 167 per 1000	Caesarean birth: 250 per 1000	Caesarean birth: 83 more per 1000 (85 fewer to 603 more)
Injectable prostaglandin	Not reported by included studies	–	1.40 (0.09 to 20.66)	⊕◯◯◯ VERY LOW [a]	1.40 (0.09 to 20.66)	⊕◯◯◯ VERY LOW [b]	82 per 1000	115 per 1000	33 more per 1000 (75 fewer to 1000 more)
							Vaginal birth: 76 per 1000	Vaginal birth: 106 per 1000	Vaginal birth: 30 more per 1000 (69 fewer to 1000 more)
							Caesarean birth: 167 per 1000	Caesarean birth: 234 per 1000	Caesarean birth: 67 more per 1000 (152 fewer to 1000 more)
Ergometrine	13.39 (2.01 to 89.44)	⊕⊕◯◯ LOW [f]	12.42 (0.91 to 168.67)	⊕◯◯◯ VERY LOW [g]	8.54 (2.12 to 34.48)	⊕⊕◯◯ LOW [h]	82 per 1000	700 per 1000	618 more per 1000 (92 more to 2745 more)

							Vaginal birth: 76 per 1000	Vaginal birth: 649 per 1000	Vaginal birth: 573 more per 1000 (85 more to 1000 more)
							Caesarean birth: 167 per 1000	Caesarean birth: 1000 per 1000	Caesarean birth: 1000 more per 1000 (187 more to 1000 more)
Ergometrine plus oxytocin		2.00 (0.29 to 13.97)	⊕⊕◯◯ LOW [i]	5.16 (0.63 to 42.13)	⊕◯◯◯ VERY LOW [j]	2.48 (0.89 to 6.88)	⊕⊕◯◯ LOW [k]	82 per 1000	203 per 1000	121 more per 1000 (9 fewer to 482 more)
								Vaginal birth: 76 per 1000	Vaginal birth: 188 per 1000	Vaginal birth: 112 more per 1000 (8 fewer to 447 more)
								Caesarean birth: 167 per 1000	Caesarean birth: 414 per 1000	Caesarean birth: 247 more per 1000 (18 fewer to 982 more)
Misoprostol plus oxytocin		Not reported by included studies	-	Not reported by included studies	-	Not reported by included studies	-	see comment*	see comment**	see comment***

The assumed risks in the oxytocin group are based on weighted means of baseline risks from the studies with oxytocin groups in the network meta-analysis.**The corresponding risks in the carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin groups** (and their 95% confidence interval) are based on the assumed risk in the oxytocin group and the **relative effect** of individual uterotonic when compared with oxytocin (and its 95% CI) derived from the network meta-analysis

* No included studies or there are no event in included studies to estimate the baseline risk
** Absolute risk with uterotonic cannot be estimated in the absence of absolute risk with oxytocin
*** Risk difference cannot be estimated in the absence of absolute risks with intervention and oxytocin
CI: Confidence interval; **RR:** Risk ratio.

GRADE Working Group grades of evidence
High certainty: We are very confident that the true effect lies close to that of the estimate of the effect
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Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

[a] Indirect evidence downgraded -3 due to multiple limitations in study design, very serious imprecision and severe unexplained statistical heterogeneity
[b] Network evidence downgraded -3 due to very low certainty indirect evidence (no intransitivity or incoherence, network estimate remains imprecise)
[c] Direct evidence downgraded -3 due to multiple limitations in study design and very serious imprecision
[d] Indirect evidence downgraded -2 due to multiple limitations in study design, serious imprecision and severe unexplained statistical heterogeneity
[e] Network evidence downgraded -2 due to low certainty indirect evidence (no intransitivity or incoherence, network estimate remains imprecise)
[f] Direct evidence downgraded -2 due to multiple limitations in study design and severe unexplained statistical heterogeneity
[g] Indirect evidence downgraded -3 due to multiple crucial limitations in study design and severe unexplained statistical heterogeneity
[h] Network evidence downgraded -3 due to very low certainty indirect evidence (no intransitivity, incoherence or imprecision; although CI is wide there is a clear increase in this outcome for ergometrine)
[i] Direct evidence downgraded -2 due to severe unexplained statistical heterogeneity and serious imprecision
[j] Indirect evidence downgraded -3 due to multiple limitations in study design and very serious imprecision
[k] Network evidence downgraded -2 due to low certainty direct evidence (no intransitivity or incoherence, network estimate remains imprecise)

Patient or population: women in the third stage of labour
Interventions: carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin
Comparison (reference): oxytocin
Outcome: fever
Setting: hospital or community setting

Uterotonic agent(s)	Direct evidence		Indirect evidence		NMA evidence		Anticipated absolute effects for NMA estimate		
	RR (95% CI)	Certainty	RR (95% CI)	Certainty	RR (95% CI)	Certainty	Risk with oxytocin	Risk with intervention (other uterotonics)	Risk difference with intervention
Carbetocin	1.58 (0.27 to 9.35)	⊕⊕⊕◯ MODERATE [a]	0.77 (0.18 to 3.42)	⊕⊕◯◯ LOW [b]	1.07 (0.43 to 2.69)	⊕⊕⊕◯ MODERATE [c]	29 per 1000	31 per 1000	2 more per 1000 (17 fewer to 49 more)
							Vaginal birth: 24 per 1000	Vaginal birth: 26 per 1000	Vaginal birth: 2 more per 1000 (14 fewer to 41 more)
							Caesarean birth: 55 per 1000	Caesarean birth: 59 per 1000	Caesarean birth: 4 more per 1000 (31 fewer to 93 more)
Misoprostol	3.75 (2.73 to 5.15)	⊕⊕◯◯ LOW [d]	6.49 (2.24 to 18.76)	⊕⊕⊕◯ MODERATE [e]	3.87 (2.90 to 5.16)	⊕⊕⊕◯ MODERATE [c]	29 per 1000	112 per 1000	83 more per 1000 (55 more to 121 more)
							Vaginal birth: 24 per 1000	Vaginal birth: 93 per 1000	Vaginal birth: 69 more per 1000 (46 more to 100 more)

							Cae-sarean birth: 55 per 1000	Caesarean birth: 213 per 1000	Caesarean birth: 158 more per 1000 (105 more to 229 more)
Injectable prostaglandin	2.00 (0.18 to 21.71)	⊕◯◯◯ VERY LOW [f]	0.96 (0.24 to 3.87)	⊕⊕◯◯ LOW [b]	1.12 (0.33 to 3.86)	⊕⊕◯◯ LOW[g]	29 per 1000	32 per 1000	3 more per 1000 (19 fewer to 83 more)
							Vaginal birth: 24 per 1000	Vaginal birth: 27 per 1000	Vaginal birth: 3 more per 1000 (16 fewer to 69 more)
							Caesarean birth: 55 per 1000 (for cae-sarean birth)	Caesarean birth: 61 per 1000 (for cae-sarean birth)	Caesarean birth: 6 more per 1000 (37 fewer to 153 more)
Ergometrine	2.97 (0.97 to 9.05)	⊕◯◯◯ VERY LOW [f]	0.63 (0.35 to 1.16)	⊕⊕◯◯ LOW [h]	0.77 (0.44 to 1.35)	⊕◯◯◯ VERY LOW [i]	29 per 1000	22 per 1000	7 fewer per 1000 (16 fewer to 10 more)
							Vaginal birth: 24 per 1000	Vaginal birth: 18 per 1000	Vaginal birth: 6 fewer per 1000 (13 fewer to 8 more)
							Cae-sarean birth: 55 per 1000	Cae-sarean birth: 42 per 1000	Cae-sarean birth: 13 fewer per 1000 (31 fewer to 18 more)

Ergometrine plus oxytocin	1.08 (0.48 to 2.43)	⊕⊕◯◯ LOW [j]	0.54 (0.22 to 1.32)	⊕⊕◯◯ LOW [k]	0.70 (0.35 to 1.42)	⊕⊕◯◯ LOW [l]	29 per 1000	20 per 1000	9 fewer per 1000 (19 fewer to 12 more)
							Vaginal birth: 24 per 1000	Vaginal birth: 17 per 1000	Vaginal birth: 7 fewer per 1000 (16 fewer to 10 more)
							Caesarean birth: 55 per 1000	Caesarean birth: 42 per 1000	Caesarean birth: 13 fewer per 1000 (31 fewer to 19 more)
Misoprostol plus oxytocin	2.99 (2.00 to 4.45)	⊕⊕⊕◯ MODERATE [m]	5.43 (1.48 to 19.95)	⊕⊕◯◯ LOW [n]	3.14 (2.20 to 4.49)	⊕⊕⊕◯ MODERATE [o]	29 per 1000	91 per 1000	62 more per 1000 (35 more to 101 more)
							Vaginal birth: 24 per 1000	Vaginal birth: 75 per 1000	Vaginal birth: 51 more per 1000 (29 more to 84 more)
							Caesarean birth: 55 per 1000	Caesarean birth: 173 per 1000	Caesarean birth: 118 more per 1000 (66 more to 192 more)

The assumed risks in the oxytocin group are based on weighted means of baseline risks from the studies with oxytocin groups in the network meta-analysis.**The corresponding risks in the carbetocin, misoprostol, injectable prostaglandins, ergometrine, ergometrine plus oxytocin (Syntometrine ®), misoprostol plus oxytocin groups** (and their 95% confidence interval) are based on the assumed risk in the oxytocin group and the **relative effect** of individual uterotonic when compared with oxytocin (and its 95% CI) derived from the network meta-analysis

* No included studies or there are no event in included studies to estimate the baseline risk

** Absolute risk with uterotonic cannot be estimated in the absence of absolute risk with oxytocin

*** Risk difference cannot be estimated in the absence of absolute risks with intervention and oxytocin

CI: Confidence interval; **RR:** Risk ratio.

GRADE Working Group grades of evidence

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Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

[a] Direct evidence downgraded -1 due to serious imprecision

[b] Indirect evidence downgraded -2 due to multiple limitations in study design, severe unexplained statistical heterogeneity and serious imprecision

[c] Network evidence downgraded -1 due to moderate certainty direct evidence (no intransitivity or incoherence, network estimate remains imprecise)

[d] Direct evidence downgraded -2 due to multiple limitations in study design and severe unexplained statistical heterogeneity

[e] Indirect evidence downgraded -1 due to multiple limitations in study design and serious imprecision

[f] Direct evidence downgraded -3 due to multiple limitations in study design and very serious imprecision

[g] Network evidence downgraded -2 due to low certainty indirect evidence (no intransitivity or incoherence, network estimate remains imprecise)

[h] Indirect evidence downgraded -2 due to multiple limitations in study design, severe unexplained statistical heterogeneity and strong suspicion of publication bias. The indirect estimate is imprecise, however the effect estimates for the two head-to-head comparisons in the dominant first-order loop were not imprecise, so we have not downgraded for imprecision

[i] Network evidence initially downgraded -2 due to low certainty indirect evidence; however, downgraded further -1 due to incoherence between the direct and indirect estimates (no intransitivity. Network estimate is imprecise, unlike indirect evidence, however no further downgrade considered because certainty already very low)

[j] Direct evidence downgraded -2 due to very serious imprecision

[k] Indirect evidence downgraded -2 due to multiple limitations in study design and severe unexplained statistical heterogeneity. The indirect estimate is imprecise, however the effect estimates for the two head-to-head comparisons in the dominant first-order loop were not imprecise, so we have not downgraded for imprecision

[l] Network evidence downgraded -2 due to low certainty direct and indirect evidence (no intransitivity or incoherence, network estimate remains imprecise)

[m] Direct evidence downgraded -1 due to multiple limitations in study design

[n] Indirect evidence downgraded -2 due to multiple limitations in study design and severe unexplained statistical heterogeneity

[o] Network evidence downgraded -1 due to moderate certainty direct evidence (no intransitivity, incoherence or imprecision)

DISCUSSION

Summary of main results

This network meta-analysis of 196 randomised trials (135,559 women) shows that all uterotonic agents are effective in preventing postpartum haemorrhage (PPH) ≥ 500 mL when compared with placebo or no treatment. The three highest ranked uterotonic agents were ergometrine plus oxytocin combination, carbetocin and misoprostol plus oxytocin combination. Ergometrine plus oxytocin combination and carbetocin are probably more effective uterotonic agents for preventing PPH ≥ 500 mL than oxytocin. Misoprostol plus oxytocin may also be more effective but the certainty of the evidence is low. Misoprostol, injectable prostaglandins, and ergometrine have comparable relative effects to oxytocin for preventing PPH ≥ 500 mL but again the certainty of the evidence is low.

This network meta-analysis shows all agents except ergometrine and injectable prostaglandins were effective for preventing PPH ≥ 1000 mL when compared with placebo or no treatment. Misoprostol plus oxytocin and ergometrine plus oxytocin combinations make little or no difference to PPH ≥ 1000 mL when compared with oxytocin. Ergometrine also may make little or no difference to this outcome when compared with oxytocin but the evidence was of low certainty. The evidence for carbetocin and injectable prostaglandins was of very low quality. Misoprostol is less effective against PPH ≥ 1000 mL when compared with oxytocin. Despite the comparable relative treatment effects between all uterotonics (except misoprostol) and oxytocin, ergometrine plus oxytocin, misoprostol plus oxytocin combinations and carbetocin were the highest ranked agents for PPH ≥ 1000 mL.

Misoprostol plus oxytocin reduces the use of additional uterotonics and probably also reduces the risk of blood transfusion when compared with oxytocin. Carbetocin, injectable prostaglandins and ergometrine plus oxytocin may also reduce the use of additional uterotonics but the certainty of the evidence is low. No meaningful differences could be detected between all agents for maternal deaths or severe morbidity as these outcomes were so rare in the included randomised trials where they were reported.

The two combination regimens were associated with important side effects. When compared with oxytocin, misoprostol plus oxytocin combination increases the likelihood of vomiting and fever. No included studies reported on hypertension for misoprostol plus oxytocin versus oxytocin. Ergometrine plus oxytocin probably increases the likelihood of vomiting and may make little or no difference to the risk of hypertension, however absolute effects varied considerably and the certainty of the evidence was low for this outcome.

Subgroup analyses did not reveal important subgroup differences by mode of birth (caesarean versus vaginal birth), setting (hospital versus community), risk of PPH (high versus low risk for PPH), dose of misoprostol (≥ 600 mcg versus < 600 mcg) and regimen of oxytocin (bolus versus bolus plus infusion versus infusion only).

Overall completeness and applicability of evidence

This network meta-analysis provides the relative effectiveness of all agents used for the prevention of PPH in a coherent and methodologically robust way across important clinical outcomes by combining both direct and indirect evidence, thus increasing the statistical power and confidence in the results. We found that most of the included trials reported our primary outcomes and most of the secondary outcomes. This increased the power across most of our analyses and contributed to the consistency in the ranking across all blood loss outcomes. We were thorough in our evaluation of the important potential treatment effect modifiers (mode of birth, prior risk of PPH, healthcare setting, dose, route and regimen of the agents). We did not encounter important differences in the distribution of the effect modifiers between the different comparisons. In addition, the ranking of the agents in each of the subgroups was comparable with the overall ranking. The results of the network meta-analyses were mostly consistent and where there was significant inconsistency this was likely due to unstable estimates from single studies.

Many trials excluded women with significant comorbidities and at very high risk for PPH. Women recruited to the included studies were predominantly delivered at more than 37 weeks of gestation. Most of the trials were carried out in hospital settings and with women having a vaginal birth. For women having a vaginal birth, uterotonic agent administration used to be a component of the active management of the third stage of labour, alongside controlled cord traction and early cord clamping. The most up-to-date guidelines from the WHO (WHO 2012), place emphasis on the administration of a uterotonic agent as the main aspect within this package for prevention of PPH. These guidelines state that early cord clamping is generally not advised, whilst controlled cord traction is optional where skilled birth attendants are present (WHO 2012). Rankings of the available agents were similar in subgroups where trials included either only women having a vaginal birth or only women undergoing a caesarean section. Evidently, uterine tone plays a major role in PPH at caesarean section, with a relative reduction of PPH ≥500 mL similar to the reduction seen in women undergoing vaginal births when more effective agents are used. The ranking is relevant to women at either high or low risk for PPH in hospital settings. There were not enough trials to be able to recommend a ranking in community settings, even though a similar ranking in terms of effectiveness can be expected.

The dosages, regimens and routes of administration for the most effective uterotonic agents varied. In most of the studies investigating this agent, carbetocin was administered as a single intravenous bolus of 100 mcg or intramuscularly. The combination of ergometrine plus oxytocin was usually administered intramuscularly combining 500 mcg of ergometrine plus 5 IU (international units) of oxytocin. Misoprostol plus oxytocin combinations varied greatly, with some studies administering an intravenous infusion of 20 IU of oxytocin and 400 mcg of misoprostol sublingually,

or 200 mcg of misoprostol sublingually, others administering an intravenous bolus of oxytocin of 10 IU plus 400 mcg misoprostol sublingually, while others administered an intravenous infusion of 10 IU of oxytocin and 400 mcg of misoprostol rectally. There were also several other ways of administering the misoprostol plus oxytocin combination described (see Characteristics of included studies).

Quality of the evidence

We recognise that there is no single established approach for assessing the certainty of the effect estimates generated by the network meta-analysis. We applied the rigorous method for appraising quality of network evidence as proposed by the GRADE Working group. Overall, the evidence presented varied widely in quality, and our confidence in the effect estimates ranged from very low to high certainty. When we compared oxytocin with all the other uterotonic agents and agent combinations, most individual outcomes included a range in quality of evidence across the different interventions, and this was equally true for our most important outcomes. Our reasons for downgrading the evidence also varied across comparisons and outcomes.

Summarising the quality of the evidence for the seven most important outcomes (also described in the summary of findings), for PPH $\geq$ 500 mL, moderate-certainty evidence pointed to the probable superiority of both carbetocin and ergometrine plus oxytocin when compared with oxytocin alone; in both cases this evidence was downgraded due to some concerns regarding risk of bias and unexplained statistical heterogeneity in both the direct and indirect comparisons contributing most weight to the network estimate, however the direct and indirect effect estimates were coherent with one another.

For PPH $\geq$ 1000 mL, we had high-certainty evidence that there is little difference between oxytocin and the uterotonic combinations of ergometrine plus oxytocin and misoprostol plus oxytocin, whereas misoprostol is slightly worse. For carbetocin and injectable prostaglandins, very low-certainty evidence suggested unclear effects due to imprecision, strong suspicion of publication bias for the direct evidence, and incoherence between the direct and indirect effect estimates.

We had high-certainty evidence that misoprostol plus oxytocin reduces the need for additional uterotonic agents compared to oxytocin alone, and low-certainty evidence suggested that carbetocin, injectable prostaglandins and ergometrine plus oxytocin may all also reduce the use of additional uterotonics. The low-certainty findings were all downgraded due to risk of bias and unexplained statistical heterogeneity, with findings on injectable prostaglandins and ergometrine plus oxytocin also being downgraded for imprecision. Moderate-certainty evidence suggested misoprostol plus oxytocin may reduce the need for blood transfusion compared to oxytocin, with the evidence being downgraded due to imprecision.

The quality of the evidence on side effects was also somewhat varied, although with less variation within the evidence for each individual outcome. For vomiting, most of the findings were high or moderate certainty, with the main reasons for downgrading being concerns about risk of bias and imprecision. For hypertension, the evidence was all low or very low quality due to wide-ranging concerns about risk of bias, imprecision and unexplained statistical heterogeneity. The evidence on fever ranged from moderate to very low certainty, and we had most confidence in the finding that misoprostol alone or in combination with oxytocin led to a considerable increase in this outcome for women. We downgraded these findings due to concerns about risk of bias, severe unexplained statistical heterogeneity and imprecision.

Potential biases in the review process

Several authors have been involved in one or more previous or ongoing trials related to the use of uterotonics for the prevention of PPH that could be eligible for inclusion in this review. They did not participate in any decisions regarding these trials (i.e. assessment for inclusion/exclusion, trial quality, data extraction) for the purposes of this review - these tasks were carried out by other members of the team who were not directly involved in the trials. The quality of the evidence was assessed by a team of authors based in different countries. Before we could GRADE the network meta-analysis evidence, we had to determine the methodology for this process because there is no well-established approach or accompanying tools such as software. All GRADE assessments were undertaken by one individual (MJW, VD, MC or JP) and then re-assessed independently by another of those four authors, in consultation with OTO and JPV where additional decision-making was required.

The earliest included trial was conducted in 1976 (Moodie 1976), and in the decades since then, the clinical care and the clinical response to PPH may have improved. These temporal changes could have contributed to heterogeneity and increased the uncertainty of findings. However, we carried out a sensitivity analysis by removing trials published before 1990 and this did not vary the ranking of the agents. As objective methods of measuring blood loss became increasingly available this could perhaps have also led to apparent changes in reported blood loss. The trials included in the review recruited women with varied clinical characteristics, and it is important to consider this when interpreting results. The inclusion criteria were not always reported in detail and, when they were, these varied across trials. Further heterogeneity may also be present in the overall analysis related to the dose, route or regimen of the uterotonic agents. Even though we did not observe subgroup effects when we examined the dose of misoprostol or regimen of oxytocin administration, we were not able to perform subgroup analyses for every single increment in dosage or route of administration. Lastly, not all trials reported data on side effects, hence these analyses were often underpowered.

Agreements and disagreements with other studies or reviews

In this update of the review first published in April 2018, we have incorporated results from a large WHO trial (Widmer 2018) and overall, 56 new trials involving 46,612 women. The conclusions remain largely the same. The results for the primary outcome of PPH ≥ 500 mL were similar to the previously published review (Gallos 2018), although the quality of the evidence for carbetocin has changed from 'very low-' to 'moderate-certainty evidence' for this outcome, due to the addition of data from three studies including approximately 30,000 women. For the primary outcome of PPH ≥ 1000 mL, none of the agents is significantly more effective when compared with the reference uterotonic agent oxytocin. In the previous version of the review, high-quality evidence suggested that ergometrine plus oxytocin was more effective in reducing PPH ≥ 1000 mL in comparison to oxytocin. For all other outcomes (blood transfusion; additional uterotonics; and side effects), the results are largely the same.

Our results agree with existing Cochrane Reviews (Begley 2015; Liabsuetrakul 2018; McDonald 2004; Su 2012; Tuncalp 2012; Westhoff 2013) that focus on the comparison of a uterotonic agent versus another (direct comparisons). However, this network meta-analysis has several more studies than included in the previous reviews because of its nature of comparing all available uterotonic agents in one single analysis and because it is the most up-to-date including recently published trials. Hence, some estimates differ slightly, as expected.

AUTHORS' CONCLUSIONS

Implications for practice

The current WHO recommendation on the choice of uterotonics for preventing postpartum haemorrhage (PPH) is 10 IU of intramuscular or intravenous oxytocin (WHO 2012). We found that oxytocin has substantial desirable effects compared with placebo or no treatment and trivial side effects. As a result, the balance of effects is expected to favour oxytocin. A problem with oxytocin, though, is that it needs to be kept refrigerated (2 °C to 8 °C) to maintain its potency. Several studies have demonstrated that oxytocin loses potency if stored at room temperature for too long or at higher temperatures, making its use difficult in low-resource settings (Hogerzeil 1993; WHO 1993).

We found that ergometrine plus oxytocin combination (Syntometrine ®), misoprostol plus oxytocin combination and carbetocin have additional desirable effects compared with oxytocin, whereas misoprostol, injectable prostaglandins and ergometrine have no additional benefits compared with oxytocin. However, these uterotonic agents with the exception of carbetocin also have substantial undesirable effects as they increase the likelihood of side effects compared with oxytocin.

While the combination of ergometrine plus oxytocin may be more effective than oxytocin alone for some desirable outcomes, this combination also increases important side effects for the woman. Notably, caution should be exercised when using ergot derivatives for PPH prevention as these drugs have clear contraindications in women with underlying hypertensive or cardiovascular disorders. Thus, it is probably safer to avoid the use of ergot derivatives containing uterotonics in unscreened populations.

It is important to note that although the combination of misoprostol plus oxytocin may be more effective than oxytocin alone for some desirable outcomes, this combination also increases important side effects for the woman. In addition, as misoprostol and oxytocin are not available as a fixed drug combination (like Syntometrine®), and the two agents have to be administered through separate routes (parenteral and oral/rectal), the application of this combination may be less feasible in routine clinical settings compared with using either oxytocin or misoprostol as a single uterotonic agent. Therefore, the care provider and the parturient woman may need to carefully balance the additional benefits of a combination of misoprostol and oxytocin (over either of these agents alone) with the drawbacks (including side effects, and the challenges and inconvenience) of using two drugs through separate routes before using this combination.

There is evidence that carbetocin may be more effective than oxytocin for some desirable outcomes but with a comparable side-effect profile when compared with oxytocin. While this risk-benefit balance appears to favour carbetocin, carbetocin is more expensive and currently not widely available. A room temperature stable formulation of carbetocin is also now available, which could make it an attractive option for settings where maintaining the cold chain for storage and transport of oxytocin is problematic, if the cost limitations can be addressed. Nonetheless, despite the unit cost of carbetocin being higher than oxytocin it may still be cost-effective in high-income settings such as the UK where the cost of caring for PPH and its complication is substantial (Gallos 2018).

Before making decisions, policymakers would need to balance the desirable and undesirable effects of the range of effective uterotonics presented with their available resources and other contextual issues. An economic assessment would need to assess the consequences of various single or combination uterotonic agents compared with their current standard, with consideration of differences between their effects (benefits and harms), supply costs, and other resource requirements (staffing and training, equipment and infrastructure, staff time, supplies, supervision and monitoring). Other important considerations for decision-making include the potential impact of introducing or scaling up the uterotonic on health equity, acceptability to key stakeholders and feasibility of using these uterotonics in routine clinical practice.

Implications for research

There is still uncertainty around the best doses and routes of administration for each of the uterotonic agents. For oxytocin for example, there are uncertainties around the optimal dose at caesarean section, whether it should be administered intravenously or intramuscularly and whether it should be administered as an intravenous bolus or infusion. The current network meta-analysis analyses the effectiveness and side effects for the various agents grouping together all doses and routes of the agents analysing them at an aggregate level only. The current network meta-analysis cannot answer if a specific dose or route for any of the agents is preferred as it excludes trials that have compared different doses or routes of the same agents. We propose to update our existing network meta-analysis by adding evidence from all the trials comparing the various doses and routes for all available agents. We wish to analyse each agent by disaggregating the various doses and routes available and then analyse in the context of the network. In this way we plan to make use of both existing direct evidence and indirect evidence from the whole network. This approach potentially can give us answers about preferred doses and routes for each of the agents and identify research gaps in the evidence base.

Consultation with our consumer group demonstrated the need for more research into outcomes identified as priorities for women and their families, such as women's views regarding the agents used, severe maternal morbidity such as shock, and breastfeeding at discharge. To date, trials have rarely investigated these outcomes. Consumers also considered the side effects of uterotonic agents to be important but these were often not reported.

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* *Indicates the major publication for the study*

CHARACTERISTICS OF STUDIES

Characteristics of included studies *[ordered by study ID]*

Abdel-Aleem 1993

Methods	2-arm active-controlled randomised trial
Participants	150 women were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with risk factors for PPH: duration of labour less than 2 hours or prolonged labour more than 24 hours, MgSO4 for pre-eclampsia, chorioamnionitis, multiple pregnancy, previous PPH, APH and episiotomy
Interventions	200 mcg of ergometrine administered by an IV bolus versus 250 mcg of carboprost administered IM
Outcomes	The study recorded the following outcomes: blood loss (mL); third stage duration (minutes); diarrhoea; nausea; vomiting; abdominal pain
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Table of random numbers was used.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Blood was collected in a tray and measured. Sterile pads were placed over the vulva before and after use for a period of 4 hours
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Abdel-Aleem 1993 (*Continued*)

Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Carboprost kindly supplied by Prof. S. Bergstrom, Sweden but source(s) of funding for the study were not reported

Abdel-Aleem 2010

Methods	3-arm controlled randomised trial
Participants	1964 women were randomised in a hospital setting in Egypt and South Africa. The population comprised women of any parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with medical complications such as hypertension and diabetes, previous caesarean section, or an abdominal wall that was not thin enough to allow easy palpation of the uterus after delivery
Interventions	10 IU of oxytocin administered IM versus no treatment
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; severe maternal morbidity: intensive care admissions; additional uterotonics; transfusion; manual removal of placenta
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Allocated to 1 of 3 groups by selecting the next number in a computer-generated random number sequence
Allocation concealment (selection bias)	Low risk	The allocated group was noted inside opaque sealed envelopes
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.

Abdel-Aleem 2010 (*Continued*)

Objective assessment of blood loss	Low risk	In Assiut, investigators appraised blood loss by collection with a calibrated plastic drape placed under the mother within 30 minutes of delivery. At the East London Hospital Complex, investigators appraised blood loss by collection with a low profile plastic "fracture" bedpan placed under the mother
Incomplete outcome data (attrition bias) All outcomes	Low risk	Investigators were unable to collect outcome data from 14 randomised study participants
Selective reporting (reporting bias)	Unclear risk	The study protocol was registered retrospectively (ACTRN: 12609000372280)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the institution of the authors, or conducted without external funding

Acharya 2001

Methods	2-arm active-controlled randomised trial
Participants	60 women were randomised in a hospital setting in UK. The population comprised women of both nulliparous and multiparous, either singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria were not specified
Interventions	10 IU of oxytocin administered by an IV bolus versus 400 mcg of misoprostol administered orally
Outcomes	The study recorded the following outcomes: PPH at 1000; additional uterotonics; transfusion; blood loss (mL; change in Hb; vomiting; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.

Acharya 2001 (*Continued*)

Allocation concealment (selection bias)	Low risk	Randomisation was performed using sealed opaque envelopes
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised intra-operative blood loss by the estimation of attending physicians, and by measurement of preoperative and postoperative Hb concentration and hematocrit
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Adanikin 2012

Methods	2-arm active-controlled double-dummy randomised trial
Participants	218 women were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with altered serum electrolytes, peritonitis, sepsis, previous bowel surgery, thyroid disease, inflammatory bowel disease, or chronic constipation
Interventions	25 IU of oxytocin administered by an IV bolus + infusion versus 600 mcg plus 5 IU of misoprostol plus oxytocin administered rectally plus by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; nausea; vomiting; fever; shivering

Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Allocation sequence developed by 1 researcher (O.O.) using a computer-generated table of random numbers with varied permutated blocks
Allocation concealment (selection bias)	Low risk	Used sealed opaque envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The same researcher administered the drugs intra-operation and set up the infusions in the operating room; he was the only person who was not blind to the drug allocation and he did not take any further part in the active running of the study"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Adanikin 2013

Methods	2-arm active-controlled double-dummy randomised trial
Participants	50 women were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with asthma or with hypersensitivity to prostaglandins
Interventions	600 mcg of misoprostol administered rectally versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	1:1 computer-generated randomisation.
Allocation concealment (selection bias)	Low risk	The pharmacy department provided the study drugs and placebos in unidentifiable form but the resident doctor was responsible for the patient's allocation according to the randomisation table
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Outcome assessors were blinded.
Objective assessment of blood loss	Low risk	Investigators weighed the pads 4 hours postpartum for assessment of blood loss
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised

Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Afolabi 2010

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in Nigeria. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing induction of labour or caesarean section, or those with hematocrit of less than 30%, pre-eclampsia/eclampsia, grand multiparity (5 or more), multiple pregnancy, coagulopathy, or medical disorders
Interventions	10 IU of oxytocin administered IM versus 400 mcg of misoprostol administered orally
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; severe maternal morbidity: intensive care admissions; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes) ; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomised into 2 groups, A and B, by blocked (restrictive) double-blind randomisation using random table generated numbers
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss at delivery by collection with a large kidney dish, for measurement in a graduated measuring jar
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants

Afolabi 2010 (*Continued*)

Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Ahmed 2014

Methods	2-arm active-controlled randomised trial.
Participants	80 women were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women with risk factors for excessive blood loss e.g. those with placenta praevia or placental abruption
Interventions	100 mcg of carbetocin administered by an IV bolus versus 10 IU of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: blood loss (mL).
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	The study was "single-blind" but the identity of those blinded and the method of blinding were not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.

Ahmed 2014 (*Continued*)

Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Al-Sawaf 2013

Methods	3-arm controlled randomised trial
Participants	120 women were randomised in a hospital setting in Egypt. The population comprised women of parity 4 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing induction of labour or instrumental delivery, or those with previous caesarean section, extensive perineal, vaginal or cervical lacerations, bleeding disorders, HB less than 100 g/L, uterine malformations, grand multiparity, multiple pregnancy, polyhydramnios, intrauterine fetal death, medical problems such as pre-eclampsia, diabetes, cardiopulmonary problems, bowel disease, or allergy to prostaglandins
Interventions	No treatment versus 200 mcg of misoprostol administered sublingually versus 5 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; blood loss (mL); change in Hb
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Used closed envelopes.

Al-Sawaf 2013 (*Continued*)

Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with sterile packs weighed beforehand and afterwards
Incomplete outcome data (attrition bias) All outcomes	High risk	Quote: "Following randomisation, 16 study participants were excluded from our analysis. Of these, 14 patients received intrapartum oxytocin, 1 patient experienced extensive vaginal laceration and another experienced a cervical laceration"
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Alwani 2014

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of parity 3 or less, either singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria were not specified
Interventions	600 mcg of misoprostol administered rectally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; death; change in Hb; nausea; vomiting; hypertension; fever;.shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**

Alwani 2014 (*Continued*)

Random sequence generation (selection bias)	Low risk	The patients were randomised in 2 groups using random number table generated online (http://www.graphpad.com/quickcalcs/randomize1/)
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	No funding was sought for this study.

Amant 1999

Methods	2-arm active-controlled double-dummy randomised trial
Participants	213 women were randomised in a hospital setting in Belgium. The population comprised women of both nulliparous and multiparous, either singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with hypertensive disorders, gestational age less than 32 weeks, intrauterine fetal death, uterine malformations, inflammatory bowel disease, obliterative vascular or coronary disease, sepsis, allergy to prostaglandins or alkaloids
Interventions	600 mcg of misoprostol administered orally versus 200 mcg of ergometrine administered by an IV bolus

Amant 1999 (*Continued*)

Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; diarrhoea; nausea; vomiting; headache; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Allocation by a computer-generated list and randomisation in blocks
Allocation concealment (selection bias)	Low risk	The study box contained either 2 capsules of misoprostol and an ampoule containing placebo, or 2 capsules with placebo and an ampoule containing methylergometrine. The study boxes and capsules were indistinguishable in the 2 groups
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	High risk	Quote: "213 women were enrolled in the study, but the data for 13 were excluded because a caesarean section was performed after randomisation (n = 3), or because no predelivery (n = 3) or postpartum (n = 7, short hospital stay) blood sample was taken"
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis

Amant 1999 (*Continued*)

Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Amin 2014

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in Pakistan. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with traumatic PPH, bleeding disorders, prolonged labour, placenta praevia, placental abruption, multiple pregnancy, BMI more than 30, or previous PPH
Interventions	5 IU of oxytocin administered by an IV bolus versus 800 mcg of misoprostol administered rectally
Outcomes	The study recorded the following outcomes: PPH at 500; severe maternal morbidity: intensive care admissions; manual removal of placenta; death; blood loss (mL); third stage duration (minutes); diarrhoea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with special drapes placed under the mother until 1 hour postpartum, and weighed beforehand and afterwards. Blood was also collected in graduated plastic bags

Amin 2014 (*Continued*)

Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Askar 2011

Methods	2-arm active-controlled double-blinded randomised trial
Participants	240 women were randomised in a hospital setting in Kuwait. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women less than 18 years old and those with known or suspected coagulopathy, grand multiparity (5 or more), uterine fibroids, polyhydramnios, multiple pregnancy, fetal macrosomia, severe anaemia, cervical tears or who required prophylactic oxytocin infusion. The presence of contraindications for the use of either syntometrine or carbetocin that include pre-existing hypertension, pre-eclampsia, asthma, cardiac, renal or liver diseases, epilepsy, or history of hypersensitivity to syntometrine or carbetocin
Interventions	100 mcg of carbetocin administered IM versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); change in Hb; nausea; vomiting; hypertension; headache; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Allocation by a computer-generated code prepared before the recruitment
Allocation concealment (selection bias)	Low risk	Used sealed, consecutively-numbered, opaque envelopes

Askar 2011 (*Continued*)

Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with a new plastic sheet placed under the mother following delivery of the placenta, and weighed (together with any gauzes, tampons and pads applied during the delivery) beforehand and 2 hours afterwards. A digital scale was used for weight measurement
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Asmat 2017

Methods	2-arm active-controlled randomised trial
Participants	1678 women were randomised in a hospital setting in Pakistan. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with malpresentations such as breech, compound or transverse presentation, multiple pregnancy, placenta praevia type III, IV, placenta accreta, placental abruption, uterine rupture, myomectomy (uterine cavity opened), coagulation disorders, DIC, cardiac diseases, diabetes, and anaemia
Interventions	800 mcg of misoprostol administered rectally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; blood loss (mL)

Asmat 2017 (*Continued*)

Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	A lottery method was used.
Allocation concealment (selection bias)	High risk	Allocation concealment was not reported but unlikely to have been implemented with a lottery method of randomisation
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and care-givers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Quote: "Pads soaked were used to asses the amount of blood loss." Methods of evaluating blood loss were not reported in sufficient detail
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Attilakos 2010

Methods	2-arm active-controlled double-blinded randomised trial
Participants	377 women were randomised in a hospital setting in UK. The population comprised women of both nulliparous and multiparous, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised

	women undergoing caesarean section with general anaesthesia, gestational age less than 37 weeks performed for fetal or maternal distress where, due to time constraints, it was not possible to recruit or randomise, or those with multiple pregnancy, placenta praevia or placental abruption
Interventions	100 mcg of carbetocin administered by an IV bolus versus 5 IU of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 1000; severe maternal morbidity: intensive care admissions; additional uterotonics; transfusion; death; blood loss (mL); change in Hb; nausea; vomiting; headache; tachycardia; hypotension; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	The randomisation sequence (1:1 ratio-blocks of ten, no stratification) was generated by computer
Allocation concealment (selection bias)	Low risk	The preparation of the ampoules was undertaken by DHP Ltd. (Powys, UK) which provided sequentially numbered and labelled boxes each containing a 1-mL ampoule of the study drug. All boxes and ampoules were identically labelled, with the study number being the only differentiating feature between different drug packs. the random allocation sequence was not known to the investigators until the study had finished and the analysis was started
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Blood loss was estimated by the attending surgeon quote: "in the usual way (visual estimation, number of used swabs and amount of aspirated blood)"

Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered prospectively (EudraCT 2005-002812-94)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	Ferring Pharmaceuticals funded the cost of preparation of blinded medication ampoules. No other external funding was required for the study

Atukunda 2014

Methods	2-arm active-controlled double-dummy randomised trial
Participants	1140 women were randomised in a hospital setting in Uganda. The population comprised women of both nulliparous and multiparous, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing induction or augmentation of labour or elective caesarean section, or those with intrauterine fetal death, heart disease, severe malaria or acute bacterial infection, multiple pregnancy, antepartum haemorrhage, altered cognitive status or reported hypersensitivity to prostaglandins
Interventions	10 IU of oxytocin administered IM versus 600 mcg of misoprostol administered sublingually
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; severe maternal morbidity: intensive care admissions; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes) ; diarrhoea; nausea; vomiting; headache; fever; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	A study biostatistician generated a randomisation list with a block size of 10

Allocation concealment (selection bias)	Low risk	The study clinical pharmacist prepared the study drugs and placebos. The midwife research assistants received opaque envelopes with affixed study codes, containing both an injection (1 mL of oxytocin 10 IU or its placebo) and 3 pills (misoprostol 600 mg or its placebo)
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "To achieve blinding of the participants and assessors, both inactive agents were manufactured and packaged to resemble actual study medicines in terms of shape, size, and colour"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with a clean plastic sheet placed under the mother during and after the third stage of labour. The sheet was specifically designed and piloted for the purpose. Blood was then drained into a calibrated container to improve accuracy in blood loss measurement. Furthermore, quote: "mothers were given pre-weighed standard sanitary pads to place in the perineum at all times. These pads were changed and weighed hourly for the first 6 hours, and then every 6 hours until 24 hours postpartum. Blood loss was estimated as 1 mL per g of weight of the pad after subtracting the dry pad weight". Investigators added the estimated blood loss in pads, to the volume of blood already collected with the plastic sheet. To improve consistency in the estimation of blood loss, standardised electronic scales were used to weigh soiled sanitary pads
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered (ClinicalTrials.gov NCT01866241)

Atukunda 2014 (*Continued*)

Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by scholarship funding from the Father Bash Foundation (public funding)

Badejoko 2012

Methods	2-arm active-controlled double-dummy randomised trial
Participants	264 women were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women in the second or third stage of labour, or those with cervical lacerations or coagulopathy
Interventions	30 IU of oxytocin administered by an IV bolus + infusion versus 600 mcg plus 20 IU of misoprostol plus oxytocin administered rectally plus by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; death; blood loss (mL); vomiting; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	The randomisation code produced by an independent statistician using a computer-generated random number sequence
Allocation concealment (selection bias)	Low risk	Used sequentially numbered sealed packets made of identical opaque brown-paper envelopes prepared by the hospital pharmacy
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.

Badejoko 2012 (*Continued*)

Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with a BRASS-V calibrated drape, quote: "which is a sterile intrapartum blood collection mat with a calibrated receptacle" placed under the mother after the delivery of the baby and immediate clamping of the umbilical cord. The drape included ribbons tied around the abdomen of the mother to optimise blood collection."
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "6 women from the misoprostol group and 3 from the oxytocin group were excluded from statistical analysis. 5 of these women in the misoprostol group and all 3 in the oxytocin group were excluded because of the occurrence of cervical lacerations in them
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Low risk	The study was conducted without external funding.

Balki 2008

Methods	2-arm active-controlled double-blinded randomised trial
Participants	48 women were randomised in a hospital setting in Canada. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by emergency caesarean section. Exclusion criteria comprised women requiring general anaesthesia, or those with cardiac disease, hypertension or any condition predisposing to uterine atony and PPH, such as placenta praevia, multiple pregnancy, pre-eclampsia, macrosomia, polyhydramnios, uterine fibroids, bleeding disorders, chorioamnionitis, previous uterine atony, previous PPH or allergy/hypersensitivity to oxytocin or ergot derivatives
Interventions	250 mcg plus 20 IU of ergometrine plus oxytocin administered by an IV bolus versus 20 IU of oxytocin administered by an IV bolus + infusion
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; blood loss (mL); nausea; vomiting; hypertension; tachycardia; hypotension

Balki 2008 (*Continued*)

Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Computer-generated list of numbers.
Allocation concealment (selection bias)	Low risk	Used consecutively-numbered opaque sealed packets or envelopes
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by measurement of hematocrit preoperatively and 48 hours postoperatively
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the institution of the authors

Bamigboye 1998a

Methods	2-arm placebo-controlled randomised trial
Participants	550 women were randomised in a hospital setting in South Africa. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified

Bamigboye 1998a (*Continued*)

Interventions	400 mcg of misoprostol administered rectally versus placebo
Outcomes	The study recorded the following outcomes: PPH at 1000; additional uterotonics; manual removal of placenta; third stage duration (minutes); diarrhoea; vomiting; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated random sequence.
Allocation concealment (selection bias)	Low risk	Allocation concealment was by means of sealed, opaque containers containing 400 mg misoprostol or placebo tablets
Blinding of participants and personnel (performance bias) All outcomes	High risk	Quote: "The placebo tablets were similar in size and colour but were not identical in shape to the misoprostol tablets. Blinding of the midwife administering the tablets was therefore not possible"
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with an absorbent plastic-backed linen saver and a low-profile plastic "fracture" bedpan placed under the mother. Blood collection in the plastic bedpan continued until 1 hour after delivery of the baby. At 1 hour after delivery, all the blood on the linen saver was scooped into the bedpan with the blood already collected there, and quote: "the total blood was carefully measured". All the used linen savers and vaginal pads were weighed, and the known dry weights of these materials were subtracted from the measured total weight
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "Records of 4 of the 550 allocations (all from the placebo group) could not be traced"

Bamigboye 1998a (*Continued*)

Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Bamigboye 1998b

Methods	2-arm active-controlled randomised trial
Participants	491 women were randomised in a hospital setting in South Africa. The population comprised women of any parity, unspecified whether singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	400 mcg of misoprostol administered rectally versus 500 mcg and 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); change in Hb; third stage duration (minutes)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated random sequence.
Allocation concealment (selection bias)	Low risk	Allocation concealment was by means of sealed opaque envelopes
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and care-givers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.

Bamigboye 1998b (*Continued*)

Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	Quote: "About halfway through enrolment it was discovered that a small number of women had been excluded from the syntometrine [ergometrine plus oxytocin] group because of hypertension detected after enrolment (thus contraindicating the use of syntometrine [ergo
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the South African Medical Research Council (public funding)

Barton 1996

Methods	2-arm placebo-controlled randomised trial
Participants	119 women were randomised in a hospital setting in USA. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria were not specified
Interventions	100 mcg of carbetocin administered by an IV bolus versus placebo
Outcomes	The study recorded the following outcomes: additional uterotonics
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.

Barton 1996 (*Continued*)

Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Baskett 2007

Methods	2-arm active-controlled double-dummy randomised trial	
Participants	622 women were randomised in a hospital setting in Canada. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with placenta praevia, placental abruption, coagulopathy or unstable asthma	
Interventions	5 IU of oxytocin administered by an IV bolus versus 400 mcg of misoprostol administered orally	
Outcomes	The study recorded the following outcomes: PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death; fever; shivering	
Notes	Contact with study authors for additional information: yes. Additional data from authors: no	
Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**

Baskett 2007 (*Continued*)

Random sequence generation (selection bias)	Low risk	Computer-generated randomisation cards.
Allocation concealment (selection bias)	Low risk	Used sealed, opaque, sequentially numbered envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The packages were prepared by the hospital pharmacy and their active drug unknown to the physicians and nurses"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by a combination of the visual estimation of attending physicians and measurement of blood volume in a kidney dish placed under the mother during the third stage of labour
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the Nova Scotia Health Research Foundation (public funding)

Begley 1990

Methods	2-arm controlled randomised trial
Participants	1429 women were randomised in a hospital setting in Ireland. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, vaginal breech or instrumental delivery, or those with hypertension, epidural anaesthesia, antepartum haemorrhage, placenta praevia, placental abruption, first stage of labour more than 15 hours, "quick" delivery or needing resuscitation
Interventions	500 mcg of ergometrine administered IV bolus versus No treatment

Begley 1990 (*Continued*)

Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); third stage duration (minutes); nausea; vomiting. Hypertension. Headache. Abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Random number tables were used. The first number was selected from the table and the numbers were then allocated in blocks of 100, following in sequence
Allocation concealment (selection bias)	Low risk	Used numbered, sealed envelopes
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	High risk	Assessors were not blinded to treatment allocations.
Objective assessment of blood loss	Low risk	A sterile receiver was placed against the perineum to collect the blood lost and was measured
Incomplete outcome data (attrition bias) All outcomes	Low risk	No losses but dropouts for change in Hb.
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by public funding, or conducted without external funding

Begum 2015

Methods	2-arm active-controlled randomised trial
Participants	100 women were randomised in a hospital setting in Bangladesh. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by caesarean. Exclusion criteria were not specified
Interventions	400 mcg of misoprostol administered sublingually versus 20 IU of oxytocin administered by an IVinfusion
Outcomes	The study recorded the following outcomes: (No outcome data found)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Bellad 2012

Methods	2-arm active-controlled double-dummy randomised trial
Participants	652 women were randomised in a hospital setting in India. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section or instrumental delivery, or those with medical disorders, in active labour with more than 4 cm dilatation or stillbirths
Interventions	400 mcg of misoprostol administered sublingually versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death blood loss (mL); third stage duration (minutes); diarrhoea; nausea; vomiting; fever; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Paticipants were assigned to treatment with a 1 : 1 ratio using computer-generated simple randomisation
Allocation concealment (selection bias)	Low risk	The study medications and placebos were packaged in appropriately coded envelopes by administrative staff from the department of clinical pharmacy
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with a BRASS-V calibrated drape placed under the mother before delivery of the baby. Quote: "The calibrated blood collection receptacle was opened after delivery and drainage of amniotic fluid. The blood collected in the drape was transferred to a measuring jar with 10-mL calibrations for accuracy. Blood-soaked swabs were weighed in g, and the known dry

Bellad 2012 (*Continued*)

		weight of the swabs was subtracted; this volume was added to the measured blood volume from the drape (assuming an equivalence of 1 g and 1 mL)". Blood loss was measured at 1 and 2 hours after delivery of the baby
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The study protocol was registered retrospectively (ClinicalTrials.gov NCT01373359)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from Jawaharlal Nehru Medical College (the institution of the authors). Study medications were donated by Cipla (misoprostol) and AstraZeneca (oxytocin)

Benchimol 2001

Methods	3-arm controlled randomised trial	
Participants	602 women were randomised in a hospital setting in France. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with gestational age less than 32 weeks, previous PPH, intrauterine fetal death, previous uterine scar, multiple pregnancy or pre-eclampsia	
Interventions	No treatment versus 2.5 IU of oxytocin administered by an IV bolus versus 600 mcg of misoprostol administered orally	
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; blood loss (mL) ; change in Hb; vomiting; fever; shivering	
Notes	Contact with study authors for additional information: no. Additional data from authors: no	
Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**

Benchimol 2001 (*Continued*)

Random sequence generation (selection bias)	Low risk	Slips with the words "control," "Syntocinon," and "Cytotec" were placed into envelopes which were then drawn at random upon admission into the delivery room to determine to which group the woman would belong
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by weighing (methods of collecting blood were not reported)
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Bhatti 2014

Methods	2-arm active-controlled randomised trial
Participants	120 women were randomised in a hospital setting in Pakistan. The population comprised women of parity 4 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with medical disorders, multiple pregnancy, instrumental births, stillbirths and over 42 weeks
Interventions	400 mcg of Misoprostol administered sublingually versus 10 IU of Oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; death; blood loss (mL); nausea; vomiting; fever; shivering

Bhatti 2014 (*Continued*)

Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	1:1 simple randomisation but the sequence generation was not reported in sufficient detail
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Visual assessment of blood loss.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Bhullar 2004

Methods	2-arm placebo-controlled randomised trial
Participants	756 women were randomised in a hospital setting in USA. The population comprised women of any parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with a bleeding disorder
Interventions	200 mcg plus 20 IU of misoprostol plus oxytocin administered sublingually plus by an IV infusion versus 20 IU of oxytocin administered by an IV infusion

Bhullar 2004 (*Continued*)

Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes; vomiting; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Agent vials were coded with a number, which had been assigned using a random number table
Allocation concealment (selection bias)	Low risk	Used opaque vials containing either a 200 mcg misoprostol tablet or a placebo
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Quote: "The placebo tablets were similar in size and colour, but not identical in shape to the misoprostol tablet"
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Quote:"The placebo tablets were similar in size and colour, but not identical in shape to the misoprostol tablet"
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Biswas 2007

Methods	2-arm active-controlled randomised trial
Participants	100 women were randomised in a hospital setting in India. The population comprised women of gravida 3 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with heart, renal or liver disease, previous caesarean and severe hypertension
Interventions	125 mcg of carboprost administered IM versus 200 mcg of ergometrine administered IM
Outcomes	The study recorded the following outcomes:transfusion; manual removal of placenta; nausea; vomiting; hypertension; fever
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and care-givers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Weighed blood clots and vaginal pads before and after use.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any in-complete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Borruto 2009

Methods	2-arm active-controlled randomised trial
Participants	104 women were randomised in a hospital setting in Italy. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women with toxemia, eclampsia or epilepsy
Interventions	100 mcg of carbetocin administered by an IV bolus versus 10 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; blood loss (mL); vomiting; headache; hypotension; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Quote: "The patients were divided in two groups with blinding to the study medication". Blinding of caregivers was not confirmed
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by quote: " a sensitive colorimetric method"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised

Funding source	High risk	The authors, quote: "do not have a financial relationship with the organisation that sponsored the research". No other source(s) of funding for the study were reported

Boucher 1998

Methods	2-arm active-controlled double-dummy randomised trial
Participants	60 women were randomised in a hospital setting in Canada. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with heart disease or cardiac arrhythmia, hypertension or liver/renal/endocrine disease
Interventions	100 mcg of carbetocin administered by an IV bolus versus 32.5 IU of oxytocin administered by an IV bolus + infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; death; blood loss (mL); nausea; vomiting; headache; fever; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Double-blinded.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by a sensitive colorimetric measurement of the Hb concentration of blood loss collected, quote: "by means of aspiration from the operative field [that] began immediately after administration of the study drug and ceased at the time of skin closure. All

		gauzes used during this timeframe were placed in 15% Lyse solution. All aspirated blood, gauzes, and the reference blood sample were sent to the laboratory for quantification of total blood volume. Blood on gauzes was extracted with Lyse solution, and haemoglobin content was determined with a sensitive colorimetric method adapted to the Cobas FARA analyser. Haemoglobin concentration is proportional to the absorbance of a hydrogen peroxide-activated aminophenazone-phenol mixture measured at a wavelength of 500 nm. The inter-assay coefficient of variation averaged 3.3%, and the limit of detection of the assay was 14 mg/dL. The amount of blood collected in gauzes was calculated with the following formula: blood loss in dL = amount of haemoglobin in surgical gauzes in mg/haemoglobin concentration in mg/dL before caesarean section. Total blood loss was calculated by means of summing the volumes of blood aspirated and collected with gauzes"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "3 patients who received general instead of epidural anaesthesia were excluded from the study and did not receive the study medication" but the study report did not specify whether these exclusions occurred before or after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	High risk	The study was supported by funding from Ferring Pharmaceuticals

Boucher 2004

Methods	2-arm active-controlled double-dummy randomised trial
Participants	164 women were randomised in a hospital setting in Canada. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women younger than 18 years old, or those without known PPH risk, known or suspected coagulopathy, heart disease or cardiac arrhythmia, chronic liver/renal/endocrine disease or hypersensitivity to study drugs
Interventions	100 mcg of carbetocin administered IM versus 10 IU of oxytocin administered IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; blood loss (mL); change in Hb; nausea; vomiting; headache; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generaterd randomisation codes using a block size of 4
Allocation concealment (selection bias)	Unclear risk	Used consecutively-numbered sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study was 'double-blind': Quote: "for each study subject, kits containing both the study medication and a placebo were prepared in the hospital pharmacy according to the randomisation schedule, to assure blinding of the clinical staff"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Low risk	164 women were randomised in the study, but 4 were excluded because they did not receive the study medication (3 oxytocin and 1 carbetocin) after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Boucher 2004 (*Continued*)

Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	High risk	The study was supported by funding from Ferring Pharmaceuticals

Bugalho 2001

Methods	2-arm active-controlled double-dummy randomised trial
Participants	700 women were randomised in a hospital setting in Mozambique. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing induction or augmentation of labour
Interventions	400 mcg of misoprostol administered rectally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; blood loss (mL); third stage duration (minutes); diarrhoea; vomiting; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "Neither the investigators nor the nurses participating in the study had access to the codes until the completion of the study"
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss with a metallic collector placed under the mother, from immediately after delivery of the baby until the mother was removed from the de-

Bugalho 2001 (*Continued*)

		livery room
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "A few subjects were excluded after randomisation for emergency caesarean section or incomplete data collection"
Selective reporting (reporting bias)	High risk	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of retained placenta were omitted)
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Low risk	This study was financed by the Maputo Central Hospital (the institution of the authors) and the Special Program on Research and Research Training in Human Reproduction of the WHO (public funding)

Butwick 2010

Methods	5-arm placebo-controlled randomised trial
Participants	75 women were randomised in a hospital setting in the USA. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with active labour, ruptured membranes, drug allergy, multiple pregnancy, significant obstetric disease, risk factors for PPH (abnormal placentation, fibroids, previous PPH, previous classical uterine incision) , coagulopathy or thrombocytopenia
Interventions	Placebo versus 5, 3, 1, or 0.5 IU of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; blood loss (mL); nausea; vomiting; tachycardia; hypotension
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomised using Microsoft Excel-generated random number allocations

Butwick 2010 (*Continued*)

Allocation concealment (selection bias)	Unclear risk	Used opaque envelopes containing group assignments
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The obstetrician and anaesthetist involved in each case were blinded to the oxytocin dose assignments"
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised blood loss quote: "by estimating blood collected by suction and by calculating the weight of blood on surgical swabs"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "75 patients were enrolled, and 74 patients completed the study; 1 patient was excluded due to protocol violation (obstetrician request for supplemental oxytocin despite adequate uterine tone)"
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Low risk	The study was supported by funding from the Department of Anesthesia of the Stanford University School of Medicine (the institution of the authors)

Caliskan 2002

Methods	4-arm active-controlled double-dummy randomised trial
Participants	1633 women were randomised in a hospital setting in Turkey. The population comprised women of any parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with gestational age less than 32 weeks or hypersensitivity to prostaglandins
Interventions	400 mcg plus 10 IU of misoprostol plus oxytocin administered rectally plus by an IV infusion versus 400 mcg of misoprostol administered rectally versus 10 IU of oxytocin administered by an IV infusion versus 200 mcg plus 10 IU of ergometrine plus oxytocin administered IM plus by an IV infusion

Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; change in Hb; third stage duration (minutes); diarrhoea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	The randomisation was based on a table of computer-generated blocks of random numbers
Allocation concealment (selection bias)	Low risk	Used sealed consecutively-numbered opaque envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "To overcome the limitation of the shape of the placebo, all medications were applied by midwives, but residents who treat the birth and the third stage of labour were blinded to the identity of medication. Only the midwife who applied the medication opened the envelope once to read the code and then transferred the randomisation code into another identical envelope. The identities of the placebo and active medication were also concealed from caregivers and residents who followed up the patient for the next 24 hours. The randomisation code was not broken until study completion."
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Quote: "To overcome the limitation of the shape of the placebo, all medications were applied by midwives, but residents who treat the birth and the third stage of labour were blinded to the identity of medication. Only the midwife who applied the medication opened the envelope once to read the code and then transferred the randomisation code into another identical envelope. The identities of the placebo and active medication were also concealed from caregivers and residents who followed the patient for the next 24 hours. The randomisation code was not broken until study com-

Caliskan 2002 (*Continued*)

		pletion."
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with a sterile steel bedpan and plastic bed linen. Gauzes and pads were also collected and weighed until 1 hour after delivery of the placenta
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "The study enrolled 1633 women, but the data for 27 women were excluded because of lack of predelivery (n = 13) or postpartum (n = 14, short hospital stay) haemoglobin concentrations"
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Caliskan 2003

Methods	4-arm active-controlled double-dummy randomised trial
Participants	1800 women were randomised in a hospital setting in Turkey. The population comprised women of any parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with gestational age less than 32 weeks or hypersensitivity to prostaglandins
Interventions	400 mcg plus 10 IU of misoprostol plus oxytocin administered orally plus by an IV infusion versus 400 mcg of misoprostol administered orally versus 10 IU of oxytocin administered by an IV versus 200 mcg plus 10 IU of ergometrine plus oxytocin administered IM plus by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no
Risk of bias	

Caliskan 2003 (*Continued*)

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Computer-generated without any blocking or stratification.
Allocation concealment (selection bias)	Low risk	Used sealed, consecutively-numbered opaque envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The placebo tablets were similar in size and colour but were not identical in shape to the misoprostol tablets. To minimise this limitation, the preparation and administration of the medication were carried out by a midwife who had not been involved in the management of the patient except for drug administration."
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Quote: "The placebo tablets were similar in size and colour but were not identical in shape to the misoprostol tablets. To minimise this limitation, the preparation and administration of the medication were carried out by a midwife who had not been involved in the management of the patient except for drug administration."
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with a sterile steel bedpan and plastic bed linen from immediately after delivery. Gauzes and pads were also collected 1 hour after delivery of the placenta and weighed
Incomplete outcome data (attrition bias) All outcomes	High risk	Quote: "The data for 226 patients were excluded because of caesarean deliveries performed after randomisation (n = 206) and the lack of predelivery (n = 6) or postpartum (n = 14, short hospital stay) haemoglobin concentrations."
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Carbonell 2009

Methods	2-arm active-controlled randomised trial
Participants	1410 women were randomised in a hospital setting in Spain. The population comprised women of parity 4 or less, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section or instrumental delivery, or those with gestational age less than 32 weeks, coagulopathy, Hb less than 80 g/L, liver or kidney disorder, grand multiparity (5 or more), hypersensitivity or any contraindication for use of prostaglandins
Interventions	400 mcg and 200 mcg plus 10 IU of misoprostol plus oxytocin administered sublingually and rectally plus IM versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; severe maternal morbidity; intensive care admissions; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes) ; NNU admissions; diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Random assignments generated by computer.
Allocation concealment (selection bias)	Low risk	Used sequentially-numbered, opaque, sealed envelopes prepared by people not related to the study. This process was supervised by an analyst. Every morning a secretary received the sealed envelopes for distribution and this process was monitored by someone working on the study
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	After delivery of the baby, investigators appraised blood loss by collection with a sterile waterproof cloth placed under the mother, to channel blood into a bottle with capacity of 2 L: the volume reading was collected

Carbonell 2009 (*Continued*)

		once beyond the third stage of labour
Incomplete outcome data (attrition bias) All outcomes	Low risk	1410 women were randomised in the study, but 10 were excluded because they did not receive the allocated agents (3 in the misoprostol plus oxytocin group and 7 in the oxytocin group) after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Low risk	The study was supported by the Science and Ethics Committee of the Hospital Eusebio Hernandez in Habana, Cuba in conjunction with the Clinica Mediterranea Medica in Valencia, Spain (the institutions of the authors)

Carrillo-Gaucin 2016

Methods	2-arm active-controlled randomised trial
Participants	120 women were randomised in a hospital setting in Mexico. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by emergency caesarean section. Exclusion criteria comprised women with allergies to oxytocin or carbetocin or previous coagulation disorder
Interventions	unspecified dose of carbetocin administered by an unspecified route versus unspecified dose of oxytocin administered by an unspecified route
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; blood loss (mL)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Simple randomisation but sequence generation was not reported in sufficient detail
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.

Carrillo-Gaucin 2016 (*Continued*)

Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	It is mentioned that the study was double blinded but blinding methods (of study participants and caregivers) was unclear
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Low risk	There were 3 losses to follow-up.
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Cayan 2010

Methods	4-arm controlled randomised trial
Participants	160 women were randomised in a hospital setting in Turkey. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women with thyroid disorder, inflammatory bowel disease or other bowel diseases, previous bariatric surgery or hypersensitivity to prostaglandins
Interventions	200, 400, or 600 mcg of misoprostol plus oxytocin administered rectally plus by an IV infusion versus 10 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: fever; shivering.
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement

Cayan 2010 (*Continued*)

Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Chalermpolprapa 2010

Methods	2-arm placebo-controlled randomised trial
Participants	120 women were randomised in a hospital setting in Thailand. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by caesareans. Exclusion criteria were not specified
Interventions	Unspecified dose of misoprostol plus oxytocin administered by an unspecified route versus unspecified dose of oxytocin administered by an unspecified route
Outcomes	The study recorded the following outcomes: (No outcome data found)
Notes	Contact with study authors for additional information: yes. Additional data from authors: no
Risk of bias	

Chalermpolprapa 2010 (*Continued*)

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Chandhiok 2006

Methods	2-arm cluster-controlled randomised trial
Participants	1200 women were randomised in a community setting in India. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with multiple pregnancy, known systemic disease or previous uterine surgery, or who were designated as high risk and scheduled for transfer to an advanced care facility at the time of labour
Interventions	600 mcg of misoprostol administered orally versus 200 mcg of ergometrine administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); third stage

Chandhiok 2006 (*Continued*)

	duration (minutes; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Randomisation process not explained in sufficient detail.
Allocation concealment (selection bias)	Low risk	Randomisation process not explained in sufficient detail but lack of allocation concealment usually not an issue in cluster trials
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Not applicable.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Not applicable.
Objective assessment of blood loss	Low risk	Immediately after the cord was clamped and cut, the paramedical worker in both groups placed a calibrated blood collection drape (BRASS-V drape) under the women's buttocks for quantification of blood loss. This consists of a plastic sheet to which a funnelled pouch is attached. The volume of blood collected in the first hour was recorded. In the event of persistent bleeding, another measurement was made at the end of 2 hours
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised

Chandhiok 2006 (*Continued*)

Funding source	Low risk	This ICMR Task Force study was funded in part by the WHO Country Office, New Delhi; Cipla Pharmaceuticals provided the misoprostol tablets

Chaudhuri 2010

Methods	2-arm active-controlled double-dummy randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women undergoing caesarean section for cord prolapse or bradycardia, or those with cardiovascular, respiratory, liver or haematological disorders or known hypersensitivity to prostaglandins
Interventions	800 mcg of misoprostol administered rectally versus 40 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; severe maternal morbidity; intensive care admissions; additional uterotonics; transfusion; death; blood loss (mL); change in Hb; vomiting; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomised using computer-generated random numbers in a 1:1 ratio
Allocation concealment (selection bias)	Low risk	The packets containing the 2 drugs were sealed and opaque, and could not be identified by the surgeons and anaesthetists
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The packets containing the 2 types of drug were sealed and opaque, and could not be identified by the surgeons and anaesthetist"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Inves- tigators appraised intraoperative blood loss by collection with a suction bottle for volu-

Chaudhuri 2010 (*Continued*)

		metric measurement, combined with linen savers and mops weighed before and after delivery. They added the approximate volume of the contents of the suction bottle (a) to the difference in weight between dry (b) and soaked (c) linen savers and mops (1 g equivalent to 1 mL). Amniotic fluid volume (d) was calculated by multiplying amniotic fluid index by 30 mL. Finally, intraoperative blood loss was determined by subtracting amniotic fluid volume from approximate blood loss ((a + (c - b)) - d). Furthermore, investigators appraised postoperative bleeding over the next 8 hours by weighing soaked pads and subtracting the dry weight
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "4 women in group 1 [misoprostol] and 6 women in group 2 [oxytocin] were excluded from the analysis: 4 women required conversion to general anaesthesia, 5 women had traumatic intraoperative bleeding (extension of lower segment incision or broad ligament"
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered (CTRI 2009/091/000075)
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Chaudhuri 2012

Methods	2-arm active-controlled double-dummy randomised trial
Participants	530 women were randomised in a hospital setting in India. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing augmentation of labour, caesarean section or instrumental delivery, or those with risk factors for PPH, including BMI more than 30, grand multiparity (5 or more), polyhydramnios, fetal macrosomia, antepartum haemorrhage, prolonged labour, previous PPH, Hb less than 80 g/L, severe pre-eclampsia, asthma or coagulopathy

Interventions	400 mcg of misoprostol administered sublingually versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death. Blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated random number sequence.
Allocation concealment (selection bias)	Low risk	Used pre-prepared sealed and opaque packet.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The misoprostol and placebo tablets were similar in size, shape, and colour. The ampoules of oxytocin and placebo were also similar. Selection, enrolment, and randomisation were done by the resident doctors, whereas preparation of packets and confidential record maintenance was done by the labour room nursing staff in charge."
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Quote: "Investigators appraised blood loss by collection with specially designed, preweighed absorbent thick cotton pads with plastic lining, placed under the mother. Blood clots, if any, were expressed from the vagina into a polythene bag. Any episiotomy wound was repaired immediately, and the swabs used for the purpose of episiotomy were not included in blood loss assessment. If necessary, pads were replaced during the observational hour after delivery. Then the soaked pad(s) and the blood clots were weighed. "The specific gravity of blood being 1.08, the amount of blood

Chaudhuri 2012 (*Continued*)

		lost in mL was approximately equal to the weight in g"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "2 women in the study group and 1 woman in the control group refused sublingual administration of the drug"
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered (CTRI 2009/091/000672)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Chaudhuri 2015

Methods	2-arm active-controlled double-dummy randomised trial
Participants	396 women were randomised in a hospital setting in India. The population comprised women of parity 5 or less, either singleton or multiple pregnancy, at high risk for PPH, who delivered by emergency caesarean section. Exclusion criteria comprised women requiring conversion to general anaesthesia, or those with cardiovascular, hepatic, or haematologic disorders or any contraindication for the use of misoprostol or oxytocin
Interventions	400 mcg plus 20 IU of misoprostol plus oxytocin administered sublingually plus by an IM bolus and IV infusion versus 20 IU of oxytocin administered IM bolus plus an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; death; blood loss (mL); change in Hb; diarrhoea; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was done using a computer-generated random number sequence and blocks of size 8

Allocation concealment (selection bias)	Low risk	Assignments were contained in sealed, opaque and sequentially-numbered packets
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "Randomisation and confidential record maintenance were performed by residents who were not involved in the trial, and the operation theatre midwife prepared the sealed packets and allocated and administered the drugs. Thus, clinicians, investigators, data analysts, and participants were masked to the treatment allocation."
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Inves- tigators appraised intraoperative blood loss from after delivery of the placenta. Blood was collected with a suction bottle, linen savers and mops: the dry weights of these materials were subtracted from the soaked weights, and the total volume of intraoperative blood loss calculated on the basis that 1 g is equivalent to 1 mL. Investigators also appraised postoperative blood loss by weighing soaked pads
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered (CTRI 2013/05/003645)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Chaudhuri 2016

Methods	2-arm placebo-controlled randomised trial
Participants	288 women were randomised in a hospital setting in India. The population comprised women of parity 5 or less, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women who had caesareans or instrumental birth, known hypersensitivity to misoprostol and/or oxytocin, major cardiovascular, hepatic, or haematological disorders or intrauterine fetal death or stillbirth
Interventions	400 mcg plus 10 IU of misoprostol plus oxytocin administered sublingually plus IM versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; diarrhoea; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Used a computer-generated random number sequence and block randomisation (blocks of 6-8)
Allocation concealment (selection bias)	Low risk	Used sealed, opaque, and sequentially numbered packets.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Participants, investigators, and data analysts were masked to group assignment
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Participants, investigators, and data analysts were masked to group assignment
Objective assessment of blood loss	Low risk	Linens soaked with amniotic fluid were removed soon after delivery of the newborn, and a pre-weighed thick cotton pad with plastic lining was placed under the buttocks. All blood clots were removed from the vagina and kept in a plastic bag. The pad was replaced if completely soaked during the 1-hour observation period. Episiotomies were repaired immediately after complete delivery of the placenta, and cotton swabs used during this procedure

		were not included in the blood loss assessment. The difference in weight between the soaked and dry pad was added to the weight of blood clots to calculate the total blood loss (1 mL was considered equal to 1 g given the specific gravity of blood of 1.08)
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Low risk	Registered with Clinical Trial Registry India (Registration No. CTRI/2014/03/004491)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Chhabra 2008

Methods	3-arm active-controlled randomised trial
Participants	300 women were randomised in a hospital setting in India. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing augmentation of labour, caesarean section or instrumental delivery, or those with grand multiparity (more than 5), multiple pregnancy, pregnancy-induced hypertension, antepartum haemorrhage, previous caesarean, Hb less than 80 g/L, other obstetric problems or known hypersensitivity to prostaglandins
Interventions	100 or 200 mcg of misoprostol administered sublingually versus 200 mcg of ergometrine administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; death; blood loss (mL); change in Hb; third stage duration (minutes); nausea; vomiting; headache; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**

Chhabra 2008 (*Continued*)

Random sequence generation (selection bias)	Low risk	Used random number tables.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and care-givers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Investigators appraised blood loss by quote: "measuring blood and blood clots collected in sponges"
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any in-complete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Choy 2002

Methods	2-arm active-controlled randomised trial
Participants	991 women were randomised in a hospital setting in Hong Kong. The population comprised women of parity 3 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with medical conditions that precluded the use of ergometrine, such as pre-eclampsia, cardiac disease or conditions that required prophylactic oxytocin infusion after delivery such as grand multiparity (4 or more) or presence of uterine fibroids
Interventions	500 mcg plus 5 IU of ergometrine plus oxytocin administered IM versus 10 IU of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); change in Hb; nausea; vomiting; hypertension;headache

Choy 2002 (*Continued*)

Notes	Contact with study authors for additional information: yes. Additional data from authors: no	
Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated random number.
Allocation concealment (selection bias)	Low risk	Used sealed consecutively-numbered opaque envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The preparation and administration of the medication was carried out by a second midwife who was not involved in the management of the patient except for the drug administration. The medical attendant who delivered the baby was not informed of the type of oxytocics used."
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss quote: "by measuring the amount of blood clots and weighing the towels and swabs used"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Chua 1995

Methods	2-arm active-controlled randomised trial
Participants	115 women were randomised in a hospital setting in Singapore. The population comprised women of unspecified parity, a singleton pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	125 mcg of carboprost administered IM versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: additional uterotonics; manual removal of placenta; diarrhoea
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomised by a random number table.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	All blood and blood clots lost in the first 2 hours after delivery were collected by mopping the blood and clots with absorbent paper, and collect the paper in a plastic bag. The bags were sent to the laboratory for processing within 2 hours of completion of blood collection
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	115 women were randomised in the study, but 3 were excluded because they gave birth precipitously before preparing the bed for accurate collection of blood after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Chua 1995 (*Continued*)

Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Cook 1999

Methods	3-arm active-controlled randomised trial
Participants	930 women were randomised in a hospital setting in Australia, Papua and China. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing elective caesarean section, or those with coagulopathy, asthma, heart disease, severe renal disease, epilepsy or hypertension
Interventions	400 mcg of misoprostol administered orally versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; blood loss (mL); change in Hb; third stage duration (minutes) ; diarrhoea
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was by random number list in blocks of 20 with a separate randomisation for each centre
Allocation concealment (selection bias)	Low risk	Used sequentially-numbered sealed security (opaque) envelopes containing the appropriate drug label for each centre
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	High risk	Assessors were not blinded to treatment allocations.

Cook 1999 (*Continued*)

Objective assessment of blood loss	Unclear risk	Investigators appraised blood loss by combining "estimated" and "measured" values according to the standard clinical practice of each study centre. The "estimated" blood loss was judged by the attending senior midwives and/or clinicians. The "measured" blood loss was calculated as the actual volume of blood collected in a calibrated measuring jug, combined with the difference in weight between dry and blood-stained undersheets and sanitary pads
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were not collected completely from 67 study participants: quote: "the main reasons for exclusion prior to randomisation, and following randomisation but before treatment, were the need for caesarean section and development of hypertension, either before or during labour."
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Dabbaghi Gale 2012

Methods	2-arm active-controlled randomised trial
Participants	269 women were randomised in a hospital setting in Iran. The population comprised women of parity less than 3, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with previous PPH, asthma, clotting disorders, placental abruption, PPH due to lacerations, or those requiring instrumental delivery or caesarean section
Interventions	400 mcg of misoprostol administered orally versus 10 IU of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: (No outcome data found)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Dabbaghi Gale 2012 (*Continued*)

Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Dansereau 1999

Methods	2-arm active-controlled double-blinded randomised trial
Participants	694 women were randomised in a hospital setting in Canada. The population comprised women of parity 5 or less, either singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women undergoing general anaesthesia or requiring a classical uterine incision, or those with heart disease, chronic hypertension requiring treatment, liver, renal, or endocrine disorders, coagulopathy, placenta praevia or placental abruption
Interventions	100 mcg of carbetocin administered by an IV bolus versus 25 IU of oxytocin administered by an IV bolus + infusion

Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; change in Hb; nausea; vomiting; headache; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated randomisation code, stratified by centre and with use of random blocks of 2
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "All physicians and nurses involved, all investigators and their staff, and all sponsor representatives were kept blinded to the treatment codes at all times"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Low risk	694 women were enrolled in the study, but 59 were excluded because of withdrawals (n = 5) or protocol violations (n = 54) after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	High risk	The study was supported by funding from Ferring Pharmaceuticals

Dasuki 2002

Methods	2-arm active-controlled randomised trial
Participants	196 women were randomised in a hospital setting in Indonesia. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	600 mcg of misoprostol administered orally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: blood loss (mL); third stage duration (minutes); shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

de Groot 1996

Methods	3-arm placebo-controlled randomised trial
Participants	371 women were randomised in a hospital and community setting in the Netherlands. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing induction or augmentation of labour or instrumental delivery, requiring tocolysis or those who refuse to take part or with cardiac disease, multiple pregnancy, non-cephalic presentation, polyhydramnios, coagulopathy, stillbirth, antepartum haemorrhage, Hb less than 4.8 mmol/L or previous complication in third stage
Interventions	Placebo versus 5 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death;blood loss (mL)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated randomisation list.
Allocation concealment (selection bias)	Low risk	Used identical study boxes. Care was taken that no difference could be seen or heard between the packages of the ergometrine/ placebo tablets and the oxytocin ampoules
Blinding of participants and personnel (performance bias) All outcomes	High risk	The study made use of placebo tablets to minimise detection bias between the placebo and the oral ergometrine arm but also included an unblinded oxytocin arm and the comparison of oxytocin versus placebo was unblinded
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with a "fresh" perineal pad placed under the mother from immediately after birth until 1 hour after the delivery of the placenta. The difference in the weight of the pad before and after delivery was calculated on the basis that 1 g is equivalent to 1 mL of blood. "During delivery

		some blood was usually spattered on the drapes and gowns of the attendants, although attempts were made to minimise such losses. This gave a constant error of approximately 10%. In addition, the placental interstices contain maternal blood (about 9% of placental weight). As systematic overestimations (amniotic fluid) and underestimations (blood loss) are likely to be equally distributed among the groups, no corrections have been made for them"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "4 women with exclusion criteria were entered erroneously (3 forceps, 1 augmentation). They are considered as non-participants"
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Del Angel-Garcia 2006

Methods	2-arm active-controlled randomised trial
Participants	152 women were randomised in a hospital setting in Mexico. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by an unspecified method. Exclusion criteria were not specified
Interventions	unspecified dose of oxytocin administered by an unspecified route versus unspecified dose of carbetocin administered by an unspecified route
Outcomes	The study recorded the following outcomes: (No outcome data found)
Notes	Contact with study authors for additional information: no. Additional data from authors: no (Abstract only)

Risk of bias

Bias	Authors' judgement	Support for judgement

Del Angel-Garcia 2006 (*Continued*)

Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Derman 2006

Methods	2-arm placebo-controlled randomised trial
Participants	1620 women were randomised in a community setting in India. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women at high risk and inappropriate for home or community births according to India's ministry of health guidelines including those undergoing elective caesarean section or breech vaginal delivery, or those previous caesarean section, Hb less than 80 g/L, antepartum haemorrhage, hypertension, multiple pregnancy, history of previous antepartum or PPH, retained placenta, uterine inversion, diabetes, heart disease, seizures, placenta praevia, asthma or contraindications to misoprostol
Interventions	600 mcg of misoprostol administered orally versus placebo

Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; severe maternal morbidity: intensive care admissions; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Generated randomisation list with a random block size by the data co-ordinating centre and was stratified by the midwife
Allocation concealment (selection bias)	Low risk	The envelopes were numbered and each envelope had a 5-digit code number assigned to it. The first 2 digits were the auxiliary nurse midwife number, followed by a sequence number beginning with 001 and ending with 100, assigned to the individual participant. Non-distinguishable envelopes in batches of 100 were distributed to each of the midwifes affiliated with the 4 selected primary-health centres
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The identical placebo was specifically manufactured for the study"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with a polyurethane blood collection drape placed under the mother from immediately after birth until 1 hour after delivery of the baby. The blood collection drape included a calibrated receptacle specifically developed for the study. In the event of persistent bleeding beyond 1 hour, the drape was removed at 1 hour, blood loss measured, and a new drape used with a second measurement made at 2 hours
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants

Derman 2006 (*Continued*)

Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered (ClinicalTrials.gov NCT00097123)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the National Institute of Child Health and Human Development (public funding) and the Bill and Melinda Gates Foundation (public funding)

Dhananjaya 2014

Methods	2-arm active-controlled randomised trial
Participants	100 women were randomised in a hospital setting in India. The population comprised women of parity 4 or less, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with grand multiparity (not defined), rhesus negative blood group, cardiac disease, diabetes, bleeding disorder, precipitated labour, overdistended uterus, traumatic PPH, PROM/chorioamnionitis, intrauterine death, previous caesarean section/scar on uterus or inability to obtain the informed consent
Interventions	10 IU of oxytocin administered IM versus 200 mcg of ergometrine administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; transfusion; blood loss (mL); third stage duration (minutes); diarrhoea; nausea; vomiting; headache
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Systematic random sampling method.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported

Dhananjaya 2014 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with drapes that were weighed together with mops and clots, and by measurement of Hb concentration and haematocrit of a sample of venous blood before delivery and 24 hours after birth. A sample of venous blood before delivery and 24 hours after the birth was also collected, for Hb and haematocrit measurement quote: "as an objective index of blood loss"
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Diallo 2017

Methods	2-arm active-controlled randomised trial
Participants	304 women were randomised in a hospital setting in Senegal. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women who could not give their consent, those requiring a caesarean delivery and those with asthma allergy to misoprostol, pregnancies of less than 36 weeks, temperature above 38°C, chorioamnionitis, multiple pregnancy, severe cardiopathy, severe anaemia, clotting disorders, or complex perineal tear
Interventions	400 mcg of misoprostol administered orally versus 5 IU of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion' blood loss (mL); change in Hb; diarrhoea; nausea; vomiting; fever; shivering

Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	A computer-generated randomised sequence.
Allocation concealment (selection bias)	Low risk	Cards assigning patients into groups were placed in envelopes which were then sealed and numbered as and when patients were included
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	If an oxytocin drip was used during labour, it was continued for patients in the "oxytocin" group and replaced by a bottle of 5% glucose solution in the "misoprostol" group. The patient was then attended by the midwife who was not informed of the type of uterotonic administered
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Quote: "The patient was then attended by the midwife who was not informed of the type of uterotonic administered."
Objective assessment of blood loss	Low risk	The blood lost was collected in a basin placed after the clamping of the umbilical cord and the removal of the amniotic fluid. Episiotomies were repaired immediately after delivery. Blood loss was collected for up to 2 hours after delivery. This blood was transferred into a graduated jar to measure its exact volume
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	Authors did not mention any incomplete outcome data.
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	No funding sought for this study.

Diop 2016

Methods	2-arm active-controlled randomised trial
Participants	1820 women were randomised in a community setting in Senegal. The population comprised women of any parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with known allergies to prostaglandins or pregnancy complications
Interventions	600 mcg of misoprostol administered orally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: death; change in Hb; diarrhoea; nausea; vomiting; fever; shivering; maternal satisfaction.;
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	The computer-generated random allocation was overseen by Gynuity Health Projects, which also assigned clusters. Maternity huts with auxiliary midwives located 3-21 km from the closest referral centre were randomly assigned (1:1) by staff at Gynuity Health Projects to either oral misoprostol or oxytocin in Uniject, stratified by reported previous year clinic volume (deliveries) and geographical location (inland or coastal)
Allocation concealment (selection bias)	Low risk	Study drugs were packed into individually numbered single-dose envelopes by staff at Gynuity Health Projects and supplied to maternity huts by ChildFund Senegal
Blinding of participants and personnel (performance bias) All outcomes	High risk	Not blinded.
Blinding of outcome assessment (detection bias) All outcomes	High risk	Not blinded.
Objective assessment of blood loss	High risk	The perceived amount of blood loss was documented as "normal", "moderate", or "significant"
Incomplete outcome data (attrition bias) All outcomes	High risk	There were 1820 recruited initially through the clusters but 1412 were included in the

Diop 2016 (*Continued*)

		analysis and 1049 had data available for the study's primary outcome
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered prospectively (ClinicalTrials.gov, number NCT01713153)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	This study was funded by the Bill & Melinda Gates Foundation

Docherty 1981

Methods	2-arm active-controlled randomised trial
Participants	50 women were randomised in a hospital setting in UK. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	10 IU of oxytocin administered IM versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: blood loss (mL).
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.

Docherty 1981 (*Continued*)

Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Dutta 2016

Methods	2-arm active-controlled randomised trial
Participants	400 women were randomised in a hospital setting in India. The population comprised women of parity 2 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women requiring caesarean section or instrumental delivery, Hb less than 8 g/dL, APH, severe pregnancy-induced hypertension, pre-eclampsia or eclampsia, prolonged labour or precipitate labour, fetal weight > 3.5 kg, polyhydramnios, and medical disorders (cardiovascular disease, diabetes mellitus, thyroid disorders and other coagulation abnormalities
Interventions	600 mcg of misoprostol administered rectally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; transfusion; blood loss (mL) ; change in Hb; third stage duration (minutes); diarrhoea; nausea; vomiting; headache; fever; shivering; abdominal pain
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.

Dutta 2016 (*Continued*)

Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Study is stated to be double-blinded but blinding (of study participants and care-givers) was unclear
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Any blood clot which expressed from the uterus was measured in the calibrated glass container
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any in-complete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Eftekhari 2009

Methods	2-arm active-controlled randomised trial
Participants	100 women were randomised in a hospital setting in Iran. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with multiple pregnancy, prolonged labour more than 12 hours, 2 or more previous caesarean sections, previous uterine rupture, Hb less than 80 g/L,who had a history of heart, renal or liver disorders or had a coagulopathy did not enter the study
Interventions	400 mcg of misoprostol administered sublingually versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: additional uterotonics; blood loss (mL); change in Hb
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Eftekhari 2009 (*Continued*)

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	By a simple randomisation method, patients were allocated into 2 equal groups
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection in a suction bottle, and with drapes and pads beneath the mother. Amniotic fluid was suctioned and measured, and then subtracted from the total volume of the suction bottle. Meanwhile the known dry weight(s) of drapes and pads were subtracted from the soaked weights of these materials. Measurements of blood collected in the suction bottle and on drapes and pads were added together
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	High risk	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of transfusion were omitted)
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

El Behery 2015

Methods	2-arm active-controlled double-dummy randomised trial
Participants	180 women were randomised in a hospital setting in Egypt. The population comprised women of nulliparous, a singleton pregnancy, at high risk for PPH, who delivered by emergency caesarean section. Exclusion criteria comprised women undergoing elective caesarean section, vaginal delivery or general anaesthesia, or those who are multigravida, or with malpresentation, fetal anomalies, placenta praevia, diabetes, hypertension, pre-eclampsia or cardiac disease
Interventions	100 mcg of carbetocin administered by an IV bolus versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; death; blood loss (mL;. change in Hb; headache; fever
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Computer-generated code.
Allocation concealment (selection bias)	Low risk	Used sealed, opaque envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study was quote: "double-blinded": "a double dummy system for administration was used"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss quote: "in the usual way (visual estimation, number of used swabs and amount of aspirated blood)"
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	180 women were included in the study, but 100 were excluded because 4 had congenital fetal anomalies, 7 cases had placenta praevia, 5 cases were diabetic, 8 had hypertension, 9 had pre-eclampsia, 3 cases were cardiac, 28 cases needs general anaesthesia, 17 cases delivered vaginally and 19 cases delivered by elective caesarean section). It was unclear if these were excluded before

El Behery 2015 (*Continued*)

		or after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

El Tahan 2012

Methods	2-arm placebo-controlled randomised trial
Participants	382 women were randomised in a hospital setting in Egypt. The population comprised women of parity 3 or less, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with asthma, anaemia, bleeding disorders, cardiac disease, inflammatory disease, bowel disease, multiple pregnancy, pre-eclampsia, placenta praevia, placental abruption, previous APH, previous PPH, grand multiparity (not defined), fibroids, growth restriction, fetal malformations or allergy to prostaglandins
Interventions	400 mcg plus 10 IU of misoprostol plus oxytocin administered sublingually plus by an IV bolus versus 10 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: severe maternal morbidity: intensive care admissions; additional uterotonics; transfusion; death; blood loss (mL); diarrhoea; vomiting; fever; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Used a computer-generated randomisation code.
Allocation concealment (selection bias)	Low risk	Used sequentially-numbered sealed opaque envelopes.
Blinding of participants and personnel (performance bias)	Low risk	Placebo and misoprostol tables quote: "looked identical in size, colour, and pack-

El Tahan 2012 (*Continued*)

All outcomes		ing"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised intraoperative blood loss by collection in a suction bottle minus sonographically estimated amniotic fluid volume, together with visual estimates of the volume of blood on the floor and the weight differences between dry and used towels, linens, and swabs. Visual estimates were performed by obstetricians blinded to treatment allocation. Towels, linen and swabs were weighed with an electronic scale. Weights were added to volumetric values on the basis that 1 g is equivalent to 1 mL. Investigators appraised postoperative blood loss by weighing bed linen, gowns and perineal pads. Furthermore, blinded investigators estimated blood loss by multiplying maternal blood volume in mL by the difference between preoperative and postoperative hematocrit measurements, all divided by preoperative haematocrit measurements
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "4 patients in the placebo group and 12 patients in the misoprostol group were excluded from the study due to loss to follow-up or missed preoperative haematocrit data"
Selective reporting (reporting bias)	Unclear risk	The study report matches the study protocol that was registered retrospectively (ClinicalTrials.gov NCT01466530)
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Low risk	The study was supported by funding from Mansoura University (the institution of the authors)

El-Refaey 2000

Methods	2-arm active-controlled randomised trial
Participants	1000 women were randomised in a hospital setting in UK. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section or water birth, or those with severe asthma
Interventions	500 mcg of misoprostol administered orally versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes). Diarrhoea. Nausea. Vomiting. Headache. Fever. Shivering. Abdominal pain
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Statistician using computer-generated block randomisation with varying block size
Allocation concealment (selection bias)	Low risk	Used opaque, sequentially-numbered sealed envelopes
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	High risk	Assessors were not blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised

Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Elbohoty 2016

Methods	3-arm active-controlled triple-dummy randomised trial
Participants	270 women were randomised in a hospital setting in Egypt. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with hypersensitivity to oxytocin, carbetocin, or prostaglandins; contraindication to treatment with prostaglandins (e.g. glaucoma); history of significant heart disease; severe asthma; epilepsy; history or evidence of liver, renal, or vascular disease; history of coagulopathy, thrombocytopenia, or anticoagulant therapy; HELLP syndrome or eclampsia; placental abruption; or contraindication to spinal anaesthesia
Interventions	100 mcg of carbetocin administered by an IV bolus versus 400 mcg of misoprostol administered sublingually versus 30 IU of oxytocin administered by an IV bolus + infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; death; nausea; vomiting; headache; fever; shivering; abdominal pain
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was performed in a 1:1:1 ratio using a computer-generated sequence
Allocation concealment (selection bias)	Low risk	Numbered, sealed envelopes were prepared, with each envelope containing 1 of the 3 study drugs and placebos for the other 2 drugs. The randomisation protocol was concealed from the research team and the primary investigator contacted a central coordinating investigator to identify the envelope to be distributed to each patient
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Tablet placebos, containing hydrogenated castor oil, hypromellose, microcrystalline cellulose, and sodium starch glycolate were prepared to be identical in size, colour,

Elbohoty 2016 (*Continued*)

		shape, and packing to the tablet study drug. Intravenous placebo ampoules containing normal saline were prepared and were identical in shape and packing to the IV study drugs used. All envelopes were prepared by Sigma Pharmaceuticals and were already sealed when received by the research team
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Consequently, patients, investigators, and data analysts were masked to group assignments and unmasking only occurred after data analysis was completed
Objective assessment of blood loss	Low risk	Surgical towels were weighed with their wrapping before and after delivery using a highly accurate digital balance. The difference in mass between the dry and soaked towels was calculated. Operative blood loss was calculated using 3 parameters: (A) the volume of the suction bottle contents (mL) , (B) the difference in towel mass (g), and © the amniotic fluid volume (mL). Intraoperative blood loss (mL) was calculated as: Intraoperative blood loss = (A + B) −C
Incomplete outcome data (attrition bias) All outcomes	Low risk	270 women were randomised in the study, but 7 were excluded because they had general anaesthesia (n = 4) or the drug ampoules were damaged after randomisation
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered (ClinicalTrials.gov: NCT02053922)
Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Elgafor El Sharkwy 2013

Methods	2-arm active-controlled double-dummy randomised trial
Participants	380 women were randomised in a hospital setting in Egypt. The population comprised women of any parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women undergoing

	general anaesthesia, or those with coagulopathy, coronary artery disease, hypertension, PPH due to causes other than uterine atony or hypersensitivity to carbetocin
Interventions	400 mcg plus 20 IU of misoprostol plus oxytocin administered sublingually plus by an IV infusion versus 100 mcg of carbetocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: severe maternal morbidity: additional uterotonics; transfusion; death; change in Hb; nausea; vomiting; headache; hypotension; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated random number sequence.
Allocation concealment (selection bias)	Low risk	Drugs were in pre-prepared sealed and opaque packets.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Caesarean delivery was performed by 4 senior obstetricians who were blinded to the allocation
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss quote: "in the usual way (visual estimation, number of used swabs and amount of aspirated blood)"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised

Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Elsedeek 2012

Methods	2-arm placebo-controlled randomised trial
Participants	400 women were randomised in a hospital setting in Egypt. The population comprised women of parity 4 or less, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women undergoing their first elective caesarean section, or those unsure of gestation or with hypertension, diabetes, oligohydramnios, abnormal placenta or abnormal laboratory investigations
Interventions	400 mcg plus 10 IU of Misoprostol plus Oxytocin administered rectally plus by an intravenous infusion versus 10 IU of Oxytocin administered by an intravenous infusion
Outcomes	The study recorded the following outcomes: PPH at 1000; additional uterotonics; transfusion; blood loss (mL); change in Hb. NNU admissions; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated tables.
Allocation concealment (selection bias)	Unclear risk	Allocation was placed in sealed envelopes until the time of operation
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Attending obstetricians and other caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss from after uterine incision, by collection in 2 separate suction sets administered by a nurse, and by weighing surgical towels before and after each operation

Elsedeek 2012 (*Continued*)

Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The study protocol was registered retrospectively (ACTRN 12611000638932)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the institution of the authors, or conducted without external funding

Enakpene 2007

Methods	2-arm active-controlled randomised trial
Participants	864 women were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, a singleton pregnancy, at Low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with pre-eclampsia, hypertension, cardiac disease, severe anaemia, asthma, renal/hepatic disorders, grand multiparity (not defined), multiple pregnancy, polyhydramnios, previous PPH, fibroids or contraindications to misoprostol or ergometrine
Interventions	400 mcg of misoprostol administered orally versus 500 mcg of ergometrine administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; severe maternal morbidity: intensive care admissions; additional uterotonics; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; nausea; vomiting; headache; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was by simple random selection. An independent statistician generated sets of 4 random letters, which were in boxes, and each box contained 4 separate random allocations which was equivalent to an opaque sealed envelope stratified in a block of 4

Enakpene 2007 (*Continued*)

Allocation concealment (selection bias)	Low risk	Used opaque sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	The study was "single-blinded". The identity of those blinded was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by a combination of careful collection in a receptacle after the delivery of the baby, by visual estimation of blood loss, and by extrapolation of blood loss using the weight difference of the total perineal pad used up to 24 hours postpartum
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of transfusion, chest pain and abdominal pain were omitted)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the National Postgraduate Medical College and Faculty of Obstetrics and Gynecology of the University College Hospital in Ibadan, Nigeria (the institution of the authors)

Ezeama 2014

Methods	2-arm active-controlled double-dummy randomised trial
Participants	300 women were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with premature labour (less than 28 weeks), multiple pregnancy, APH, hypertension in pregnancy, severe anaemia or haemoglobinopathy

Interventions	10 IU of oxytocin administered IM versus 500 mcg of ergometrine administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); third stage duration (minutes); nausea; vomiting; hypertension; headache
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated randomisation numbers.
Allocation concealment (selection bias)	Low risk	A person uninvolved with the study prepared the study drugs. The labels on the ampoules (which were similar in size and colour) were removed and the ampoules were placed in opaque sealed envelopes
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "A person uninvolved with the study prepared the study drugs: 1-mL ampoules containing either 10 IU of oxytocin (Labtocin; Laborate Pharmaceutical India, Panipat, India) or 0.5 mg of ergometrine (Ergosav; Savorite Pharmaceuticals, Vadodara, India). The labels on the ampoules (which were similar in size and colour) were removed and the ampoules were placed in opaque sealed envelopes, such that only the computer generated randomisation numbers on the envelopes were available to identify the study drug. Both drugs were purchased from a public pharmacy."
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with "a fresh large perineal pad with plastic backing". They placed all the gauzes and perineal pads used to absorb the blood into a polythene bag, and subtracted the dry weight from the wet weight. Volume of blood loss was calculated on the basis that

Ezeama 2014 (*Continued*)

		1 g is equivalent to 1 mL
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Low risk	The study protocol was registered (PACTR 201105000292708).
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the institution of the authors

Fahmy 2015

Methods	4-arm active-controlled double-dummy randomised trial
Participants	200 women were randomised in a hospital setting in Egypt. The population comprised women of parity 4 or less, unspecified whether singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with coagulopathy, thrombocytopenia, fibroids, placenta praevia, history of previous obstetric haemorrhage more than 1 litre, and women who received anticoagulant and antiplatelets therapy
Interventions	10 IU of oxytocin administered by an IV bolus versus 100 mcg of carbetocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; blood loss (mL)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	An online randomisation program (http://ww.randomizer.org) was used to generate random list and to allocate patients into the 4 study groups
Allocation concealment (selection bias)	Low risk	Random allocation numbers were concealed in opaque closed envelops but there is no mention of the envelopes being se-

Fahmy 2015 (*Continued*)

		quentially numbered
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear as a placebo saline infusion is mentioned but no sufficient details of how blinding was achieved
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	The calculated estimated blood loss = Estimated blood volume X (preoperative PCV - postoperative PCV)/preoperative PCV. (Where estimated blood volume = Booking weight (kg) X 85 mL)
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Fahmy 2016

Methods	2-arm active-controlled randomised trial
Participants	60 women were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a twin pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with hypertension, pre-eclampsia, cardiac, respiratory, renal or liver disease, pre-existing bleeding disorder such as haemophilia and women taking therapeutic anticoagulants, hypersensitivity to carbetocin or oxytocin. Patients with Hb less than 9.5 g% and those who are pregnant with more than 2 babies
Interventions	100 mcg of carbetocin administered by an IV bolus versus 20 IU of oxytocin administered by an IV bolus

Fahmy 2016 (*Continued*)

Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; blood loss (mL)	
Notes	Contact with study authors for additional information: no. Additional data from authors: no	

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was performed by using computer-generated program
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Both drugs were prepared preoperatively and coded so that the working investigator and the obstetrician were blinded to the type of drug injected
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Fakour 2013

Methods	2-arm active-controlled double-dummy randomised trial
Participants	200 women were randomised in a hospital setting in Iran. The population comprised women of nulliparous, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	400 mcg of misoprostol administered sublingually versus 20 IU of oxytocin administered IV
Outcomes	The study recorded the following outcomes: (No outcome data found)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study used double-dummy.
Blinding of outcome assessment (detection bias) All outcomes	Low risk	The study used double-dummy.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Fararjeh 2003

Methods	2-arm active-controlled randomised trial
Participants	97 women were randomised in a hospital setting in Turkey. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing elective caesarean section or instrumental delivery, or those with premature labour (less than 37 weeks), postmaturity (more than 43 weeks), grand multiparity (more than 4), twin pregnancy, growth restriction, macrosomia, Hb less than 100 g/L, systemic disorder, prolonged third stage, manual removal of placenta or additional lacerations due to episiotomy or where it took longer than 30 minutes to repair lacerations after episiotomy
Interventions	400 mcg of misoprostol administered rectally versus 200 mcg plus 10 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; blood loss (mL) ; change in Hb
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Used urn block randomisation.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with scale vessels, and by subtraction of the dry weight(s) of cloths and pads from the soaked weight(s) of these items
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Fararjeh 2003 (*Continued*)

Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Fawole 2011

Methods	2-arm placebo-controlled randomised trial.
Participants	1345 parturients were randomised in a hospital setting in Nigeria. The population comprised multiparous women, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered vaginally. Exclusion criteria comprised severe allergic conditions or asthma, age below 18 years, pyrexia above 38°C, or abortion of the pregnancy
Interventions	400 mcg of misoprostol administered sublingually plus 10 IU of oxytocin or 250 mcg to 500 mcg of ergometrine administered IM or by an intravenous bolus (n = 658) or IV bolus versus 10 IU of oxytocin or 250 mcg to 500 mcg of ergometrine administered IM or intravenously (n = 660)
Outcomes	Could not include in the analysis as could not separate out the patients who received oxytocin from those who received ergometrine
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes, but data not provided separate for each drug used and could not be included in the meta-analysis

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Treatment was allocated in blocks of 6-8 women by the research nurse, who used a computer-generated randomisation sequence
Allocation concealment (selection bias)	Low risk	The trial drugs were concealed in sealed, sequentially numbered opaque envelopes
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Placebo was identical in shape, colour, size, and design.

Fawole 2011 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinded.
Objective assessment of blood loss	Low risk	Blood collection was initiated as soon as possible after administration of the trial medication. A low-profile plastic fracture bedpan was placed below the woman's perineum to collect all subsequent blood loss for a period of 1 hour. Blood collected in the bedpan and all blood-soaked small gauze swabs were emptied into a plastic measuring jar and the volume was measured
Incomplete outcome data (attrition bias) All outcomes	Low risk	No losses stated by authors but 27 women randomised were not included in the analysis for the primary outcome
Selective reporting (reporting bias)	Unclear risk	No available protocol.
Intention to treat analysis	Unclear risk	27 women randomised were not included in the analysis for the primary outcome
Funding source	Low risk	The trial was funded by theMedical Research Council of South Africa

Fawzy 2012

Methods	3-arm active-controlled randomised trial
Participants	300 women were randomised in a hospital setting in Egypt, Libya. The population comprised women of nulliparous, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women at high risk for PPH such as multiple pregnancy, polyhydramnios, placenta praevia, diabetes mellitus, renal disorders
Interventions	500 mcg of ergometrine administered by an IV bolus versus 200 mcg of misoprostol administered sublingually or rectally
Outcomes	The study recorded the following outcomes: death; blood loss (mL); third stage duration (minutes); shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**

Fawzy 2012 (*Continued*)

Random sequence generation (selection bias)	Unclear risk	Randomly allocated but no further details were reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	High risk	No blinding.
Blinding of outcome assessment (detection bias) All outcomes	High risk	Not blinded.
Objective assessment of blood loss	High risk	All patients were closely observed for time of placental delivery, amount of blood loss by Hb and haematocrit value pre and immediately post delivery (within 1 hour), {then calculation of estimated blood loss using the following equation EBL = (BV) X(HCTO-HCTf)/HCT where: EBL = estimated blood loss, BV: blood volume= body weight X600 cc KG&HCTO = initial haematocrit HCTf = final haematocrit HCTave = (HCTO + HCTF)/2}
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Fazel 2013

Methods	2-arm active-controlled randomised trial
Participants	100 women were randomised in a hospital setting in Iran. The population comprised women of parity 3 or less, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with twin pregnancy, fetal distress, pregnancy-induced hypertension, oligohydramnios, polyhydramnios, macrosomia, grand multiparity (4 or more), HELLP syndrome, coagulopathy, asthma, heart/

Fazel 2013 (*Continued*)

	lung/liver disease, previous more than 1 caesarean section, previous myomectomy, previous other abdominal operations, febrile diseases or sensitivity to prostaglandins
Interventions	400 mcg of misoprostol administered rectally versus 10 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: transfusion; blood loss (mL); nausea; vomiting; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Using a table of random numbers
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised intraoperative blood loss by collection with an isolated suction. The volume of blood collected in suction was combined with the volume of blood collected in gauzes and gowns: every small gauze soaked with blood was considered to contain 20 mL, and every large gauze soaked with blood 50 mL, and every g increase in the weight of a gown was considered as equivalent to 1 mL of blood
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in

		the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the Kashan University of Medical Sciences (the institution of the authors)

Fekih 2009

Methods	2-arm active-controlled randomised trial
Participants	250 women were randomised in a hospital setting in Tunisia. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women undergoing caesarean section with general anaesthesia, or those with placenta praevia, retroplacental clot, multiple pregnancy, premature labour (less than 32 weeks), intrauterine death, Hb less than 80 g/L, coagulopathy, HELLP syndrome, antepartum haemorrhage, ruptured uterus, previous more than 2 caesareans or other uterine scar, prolonged labour (more than 12 hours) or pyrexia
Interventions	200 mcg plus 20 IU of misoprostol plus oxytocin administered sublingually plus by an IV bolus and infusion versus 20 IU of oxytocin administered by an IV bolus + infusion
Outcomes	The study recorded the following outcomes: PPH at 1000; transfusion; blood loss (mL) ; change in Hb; nausea; vomiting; headache; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	The randomisation was computer-generated.
Allocation concealment (selection bias)	Low risk	A slip of paper was placed inside an opaque, sealed envelope
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised perioperative blood loss as a combination of the volume of liquid

Fekih 2009 (*Continued*)

		in the suction collection jar, and the weight of swabs and pads
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Fenix 2012

Methods	2-arm active-controlled double-dummy randomised trial
Participants	75 women were randomised in a hospital setting in Phillipines. The population comprised women of any parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with pre-existing hypertension, pre-eclampsia, diabetes, asthma, cardiac/renal diseases, coagulopathy, abnormal laboratory tests or allergy to the study medication
Interventions	100 mcg of carbetocin administered by an IV bolus versus 10 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; blood loss (mL); change in Hb; nausea; vomiting; headache; tachycardia; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated code.
Allocation concealment (selection bias)	Unclear risk	Used sealed, consecutively-numbered envelopes.

Fenix 2012 (*Continued*)

Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The patient and the principal investigator attending the delivery were blinded to the type of medication administered" [additional information from the authors]
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Quote: "The patient and the principal investigator attending the delivery were blinded to the type of medication administered" [additional information from the authors]
Objective assessment of blood loss	High risk	Investigators appraised blood loss by visual estimation, not including blood loss considered to result from repair of lacerations
Incomplete outcome data (attrition bias) All outcomes	High risk	Quote: "9 women in the carbetocin group and 6 women in the oxytocin group failed to have a paired haemoglobin test to measure the change in haemoglobin 24 hours after delivery because they refused further blood extraction. These 15 women were excluded"
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Not all study participants were included in the analysis.
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Fu 2003

Methods	2-arm controlled randomised trial
Participants	156 women were randomised in a hospital setting in China. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	400 mcg of misoprostol administered orally versus no treatment
Outcomes	The study recorded the following outcomes: PPH at 500; blood loss (mL)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Fu 2003 (*Continued*)

Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised blood loss in the 2 hours after delivery and after all amniotic fluids had been drained, by collection in a small tray and absorption into disposable, sterile, water-resistant gauze. The contents were weighed and volume was determined on the basis that 1.05 g is equivalent to 1 mL of blood. A measuring cup was used to estimate the blood in the tray; blood that soaked into the gauze was measured on the basis that material measuring 10 cm by 10 cm holds 10 mL of blood. These 3 measurements were combined to ascertain total blood loss
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Fuks 2014

Methods	2-arm active-controlled double-blinded randomised trial
Participants	143 women were randomised in a hospital setting in Jamaica. The population comprised women of parity 4 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with multiple pregnancy, grand multiparous, intrauterine fetal demise, pre-eclampsia, polyhydramnios, third- or fourth-degree laceration, and caesarean delivery
Interventions	600 mcg plus 10 IU of misoprostol plus oxytocin administered rectally plus IM versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: (No outcome data found)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and care-givers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any in-complete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly al-located to treatment were included in the analysis, in the groups to which they were randomised

Fuks 2014 (*Continued*)

Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Garg 2005

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of nulliparous, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	600 mcg of misoprostol administered orally versus 200 mcg of ergometrine administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; manual removal of placenta; third stage duration (minutes); diarrhoea; nausea; vomiting; headache; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Randomised in 1:1 ratio by random number sequence.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Garg 2005 (*Continued*)

Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Gavilanes 2016

Methods	2-arm active-controlled randomised trial
Participants	100 women were randomised in a hospital setting in Equador. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with Hb less than 80 g/L, multiple pregnancy, polyhydramnios, previous uterine rupture, bleeding disorders, intrauterine death or hyperthermia (more than 38.5C)
Interventions	400 mcg of misoprostol administered sublingually versus 10 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; blood loss (mL); nausea; vomiting; headache; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated randomisation.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised postoperative blood loss by collection with quote: "suction apparatus and sterile drapes before irrigation" and by weighing the blood collected in ab-

Gavilanes 2016 (*Continued*)

		dominal swabs and gauzes with a calibrated scale (Zhongshan Camry Electronic Co Ltd, model EK 4052-E, Guangdong, China). Investigators estimated the volume of blood loss quote: "by subtraction of amniotic fluid at 30 cc per each centimetre reported by amniotic fluid index"
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Gerstenfeld 2001

Methods	2-arm placebo-controlled randomised trial
Participants	400 women were randomised in a hospital setting in the USA. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with multiple pregnancy, coagulopathy, Hb less than 70 g/L, indication for caesarean section or contraindication to prostaglandin or oxytocin use
Interventions	400 mcg of misoprostol administered rectally versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; diarrhoea; nausea; vomiting; shivering
Notes	Contact with study authors for additional information: Yes. Additional data from authors: No

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	The randomisation was carried out by an uninvolved party and was determined by a random number sequence

Allocation concealment (selection bias)	Low risk	The random number sequence was prepared by a third party and was concealed until the patient was enrolled. Packets were prepared in advance of randomisation
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The random number sequence was quote: "concealed until the patient was enrolled" and "packets were prepared in advance of randomisation"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss (a) by collection with drapes placed under the mother. Each drape included a plastic pouch and measured volume in mL. Meanwhile the dry weights of delivery linen and sponges were subtracted from bloodied weights to determine the volume of blood collected with these materials, on the basis that 1 g is equivalent to 1 mL. The volumes of blood in drapes and linen were added together. Furthermore quote: "if amniotic fluid loss [after placement of the drape] was significant... the approximate percentage was recorded on the data sheet and blood loss was adjusted accordingly". Investigators appraised blood loss (b) by estimation of the delivery attendant(s). Investigators appraised blood loss (c) by measurement of Hb and haematocrit values were obtained on admission and on postpartum day 1. The differences between these 2 values were recorded
Incomplete outcome data (attrition bias) All outcomes	High risk	Quote: "Of the 75 women who were excluded from analysis, 73 underwent cesarean deliveries, one woman was discharged to home before delivery, and one had an initial haemoglobin of 6.8 mg/dL".
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Gerstenfeld 2001 (*Continued*)

Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Gore 2017

Methods	2-arm active-controlled randomised trial
Participants	364 women were randomised in a hospital setting in India. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women of gestational age less than 37 years, polyhydramnios, APH, pre-eclampsia, multiple pregnancy, intrauterine fetal distress, coagulation disorders, asthma, epilepsy, heart disease, kidney disease, severe anaemia with Hb less than 7 g/dL, complicated or eventful first and second stage of labour
Interventions	400 mcg of misoprostol administered orally versus 200 mcg of ergometrine administered by an IV bolus
Outcomes	The study recorded the following outcomes: change in Hb; third stage duration (minutes)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	The evaluation of blood loss was assessed by placing cotton pads under the buttocks prior to the delivery of baby. After the delivery of the placenta the total pads and linen used were weighed in grams. The weight of 1 g

Gore 2017 (*Continued*)

		of cotton pad or linen was equal to 1 mL (Langford 2000). From this the known dry weight subtracted and the calculated volume added
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The authors report no funding sources.

Gulmezoglu 2001

Methods	2-arm active-controlled double-blinded randomised trial	
Participants	18,530 women were randomised in a hospital setting in Argentina, China, Egypt, Ireland, Nigeria, South Africa, Switzerland, Thailand and Vietnam Nigeria, South Africa, Switzerland, Thailand, and Vietnam. The population comprised women of both nulliparous and multiparous, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing elective or emergency caesarean section after randomisation, or those with asthma, severe chronic allergic conditions, abortion, pyrexia (more than 38°C) or inability to give consent	
Interventions	600 mcg of misoprostol administered orally versus 10 IU of oxytocin administered IM or by an IV bolus	
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000. Severe maternal morbidity; intensive care admissions; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); third stage duration (minutes); diarrhoea; nausea; vomiting; fever; shivering	
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes	
Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**

Gulmezoglu 2001 (*Continued*)

Random sequence generation (selection bias)	Low risk	The random allocation schedule was generated centrally at WHO, Geneva, Switzerland, by computer-generated random numbers and was stratified by country. Within the strata, women were individually randomised into 1 of 2 intervention groups with randomly varying block sizes of 4-6 women
Allocation concealment (selection bias)	Low risk	The treatment packs were sealed, numbered sequentially, and could only be taken from the dispenser consecutively
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The treatment packs and their contents were identical in shape, colour, weight, and feel."
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss from the time of delivery of the baby until the third stage of the labour was completed, when the mother was transferred to postnatal care (usually up to 1 hour postpartum). Immediately after the cord was clamped and cut, they passed a flat bedpan or an unsoiled receiver under the mother. The collected blood was poured into a standard measuring jar provided by WHO for volumetric measurement. Quote: "To simplify the procedure... small gauze swabs soaked with blood were put into the measuring jar and included in the measurement together with the blood and clots"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Investigators excluded quote: "37 and 34 women with emergency caesarean section, and 13 and 4 women lost to follow-up in misoprostol and oxytocin groups, respectively, for blood loss $\geq$ 1000 mL, and 2 and 4 women without information on the need for additional uterotonics"
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was published in advance

Gulmezoglu 2001 (*Continued*)

Intention to treat analysis	High risk	Not all study participants were included in the analysis.
Funding source	Low risk	The study was supported by funding from the UNDP/UNFPA/WHO/World Bank (public funding). Special Programme of Research, Development and Research Training Human Reproduction of WHO. Searle (Skokie, IL, USA) and Novartis (Basel, Switzerland) donated the active and placebo medications used in the trial

Gupta 2006

Methods	2-arm active-controlled double-blinded randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	600 mcg of misoprostol administered rectally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); change in Hb; third stage duration (minutes); nausea; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was achieved using computer-generated random tables
Allocation concealment (selection bias)	Unclear risk	A sealed envelope with a code number was opened when vaginal delivery was imminent. The code was not broken till the end of the study
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study was "double-blind". "Each envelope contained either 3 tablets of 200 mcg misoprostol and an ampoule of normal saline or 3 identical looking placebo tablets and an ampoule of 10 IU oxytocin"

Gupta 2006 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with a BRASS-V calibrated drape placed under the mother. Pre-weighed gauzes were used to clean any perineal tears or episiotomy. After 1 hour the dry weight of the sponges was subtracted from the soiled weight, and added to the volume of blood collected in the drape on the basis that 1 g is equivalent to 1 mL
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Hamm 2005

Methods	2-arm placebo-controlled randomised trial
Participants	352 women were randomised in a hospital setting in the USA. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria were not specified
Interventions	200 mcg plus 20 IU of misoprostol plus oxytocin administered sublingually plus by an IV infusion versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 1000; additional uterotonics; transfusion; blood loss (mL); change in Hb
Notes	Contact with study authors for additional information: yes. Additional data from authors: no
Risk of bias	

Hamm 2005 (*Continued*)

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Low risk	Quote: "The group assignments were available only to the pharmacy. The nurse selected an opaque vial from the drug cabinet that contained either a 200-mg misoprostol tablet or placebo. The vial number (which had been assigned in the pharmacy) and patient identification were sent to the pharmacy."
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were unclear.

Harriott 2009

Methods	2-arm active-controlled randomised trial
Participants	140 women were randomised in a hospital setting in the West Indies. The population comprised women of both nulliparous and multiparous, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with previous PPH, hypertension, previous caesarean, intrauterine death, sepsis/pyrexia (more than 38°C), APH or Hb less than 80

	g/L
Interventions	500 mcg plus 5 IU of ergometrine plus oxytocin administered IM versus 400 mcg of misoprostol administered rectally
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb.;third stage duration (minutes); diarrhoea; nausea; vomiting; hypertension; fever; shivering; maternal satisfaction
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated block randomisation was used to randomly assign participants
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Quote: "Both the patient and the midwife conducting the delivery were aware of the drug administered"
Blinding of outcome assessment (detection bias) All outcomes	High risk	Assessors were not blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with a modified plastic drape placed under the mother from the commencement of the third stage of labour, until 1 hour after delivery. The collection drape measured 168 cm by 84 cm, and contained folded over side-wings (to act as a chute) and a 34-cm collection pouch made by folding the distal end of the drape. Standard sterile drapes were placed above the blood collection drape. Every effort was made to avoid soiling the sterile drapes before delivery of the baby, because they were not weighed. After delivery, overlying sterile drapes were removed to facilitate the use of the collection drape
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants

Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the Mona Campus and Research Publication Committee of the University of the West Indies (the institution of the authors)

Hernandez-Castro 2016

Methods	2-arm placebo-controlled randomised trial
Participants	123 women were randomised in a hospital setting in Mexico. The population comprised women of any parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by either elective or emergency caesarean delivery. Exclusion criteria comprised women with hypersensitivity to prostaglandins, hyperthermia, coagulation defects, or history of vaginal bleeding (placental abruption or placenta praevia) and those who required general anaesthesia
Interventions	400 mcg plus 20 IU of misoprostol plus oxytocin administered sublingually plus by an IV infusion versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 1000; additional uterotonics; transfusion
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was based on a computer-generated sequence in blocks of 6
Allocation concealment (selection bias)	Low risk	The drugs were kept in opaque containers, prepared by the hospital's pharmacy department, marked with the number assigned to the patient
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Patients, clinicians, investigators, and data analysts were masked to group assignment is stated but the placebo used was folic acid

Hernandez-Castro 2016 (*Continued*)

		tablets which are different shape than misoprostol
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Patients, clinicians, investigators, and data analysts were masked to group assignment is stated but the placebo used was folic acid tablets which are different shape than misoprostol
Objective assessment of blood loss	High risk	Visual estimation of blood loss was performed by the anaesthesiologist
Incomplete outcome data (attrition bias) All outcomes	Low risk	123 women were randomised in the study, but 3 were excluded because of inadequate drug administration (n = 1), uterine artery injury (n = 1) and incorrect fetal weight calculation (n = 1) after randomisation
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered prospectively (ClinicalTrials.gov:NCT01733329)
Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Hofmeyr 1998

Methods	2-arm placebo-controlled randomised trial
Participants	500 women were randomised in a hospital setting in South Africa. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing augmentation of labour, or those with hypertension, diabetes or previous caesarean
Interventions	400 mcg of misoprostol administered orally versus placebo
Outcomes	The study recorded the following outcomes:PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Hofmeyr 1998 (*Continued*)

Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated random sequence, in balanced blocks of 8.
Allocation concealment (selection bias)	Low risk	The containers were ordered according to a computer-generated random sequence, in balanced blocks of 8
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The tablets were either misoprostol 2 x 200 mcg or 2 placebo tablets similar in size and colour but not shape. Efforts to obtain identical placebo tablets were unsuccessful. This method of blinding proved to be effective. In only 1 case did the attending midwife inadvertently catch sight of the tablets
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinded.
Objective assessment of blood loss	Low risk	Within a minute of delivery, investigators removed any linen soiled with amniotic fluid, and placed a fresh, disposable absorbent linen-saver sheet with plastic backing, and a low wedge-shaped plastic "fracture" bedpan under the mother. Quote: "This was found to be a comfortable and efficient way of collecting the great majority of blood lost after delivery, and could be left in place without discomfort even during perineal suturing. When active bleeding had stopped, any blood clots were expressed from the uterus, the bedpan was removed and a sanitary towel was applied. The [volume of] blood in the bedpan was measured in a measuring jug. An hour after delivery, any bloodstained linen-savers and sanitary towels were placed in a plastic bag and weighed in g" After subtracting the known dry weights of these materials, the bloodstained weights were added to the volume of blood collected in the bedpan to ascertain the total blood loss in the first hour after delivery

Hofmeyr 1998 (*Continued*)

Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the South African Medical Research Council (public funding)

Hofmeyr 2001

Methods	2-arm placebo-controlled randomised trial
Participants	600 women were randomised in a hospital setting in South Africa. The population comprised women of any parity, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	600 mcg of misoprostol administered orally versus placebo
Outcomes	The study recorded the following outcomes:PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; diarrhoea; nausea; vomiting; fever; shivering; abdominal pain
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Random assignments generated by computer in blocks of 18.
Allocation concealment (selection bias)	Low risk	Used sequentially-numbered, opaque test tubes.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Misoprostol and placebo were similar in size and colour but not shape. Efforts to obtain identical placebo tablets were unsuccessful. This method of blinding proved to be effective

Hofmeyr 2001 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinded.
Objective assessment of blood loss	Low risk	Within a minute of delivery, investigators removed any linen soiled with amniotic fluid, and placed a fresh, disposable absorbent linen-saver sheet with plastic backing, and a low wedge-shaped plastic "fracture" bedpan under the mother. Quote: "This was found to be a comfortable and efficient way of collecting the great majority of blood lost after delivery, and could be left in place without discomfort even during perineal suturing. When active bleeding had stopped, any blood clots were expressed from the uterus, the bedpan was removed and a sanitary towel was applied. The [volume of] blood in the bedpan was measured in a measuring jug. An hour after delivery, any bloodstained linen-savers and sanitary towels were placed in a plastic bag and weighed in g" After subtracting the known dry weights of these materials, the bloodstained weights were added to the volume of blood collected in the bedpan to ascertain the total blood loss in the first hour after delivery
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "There were no withdrawals after randomisation and all outcomes were analysed in the allocated group". However the primary outcome data of 1 study participant in the placebo group were unavailable
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the South African Medical Research Council (public funding) and University of the Witwatersrand (the institution of the authors)

Hofmeyr 2011

Methods	2-arm placebo-controlled randomised trial
Participants	1103 women were randomised in a hospital setting in South Africa, Uganda, and Nigeria. The population comprised women of any parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section or instrumental delivery, or those who declined participation or were unable to consent, were too ill or distressed to participate or with a not viable pregnancy
Interventions	400 mcg plus 10 IU of misoprostol plus oxytocin administered sublingually plus IM versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes :PPH at 500; PPH at 1000; manual removal of placenta; death; blood loss (mL); fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated random numbers and was stratified by country in blocks of 6-8
Allocation concealment (selection bias)	Low risk	Quote: "The trial medication was provided, and the study drug packs were prepared, by Gynuity Health Projects. When a participant enrolled, the researcher took the next study drug pack from the dispenser and immediately wrote the woman's name both on the pack and in the participant number list, which was kept separate from the case record forms. Enrolment took place when the pack was removed from the pack dispenser. The pack could not be used for another woman or returned to the dispenser."
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study was "double-blind". Quote: "The packs were identical in shape, colour, weight, and feel, and contained either 2 tablets of 200 mcg of misoprostol (HRA Pharma, Paris, France) or 2 matching placebo tablets"

Hofmeyr 2011 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Similarly to the study team of Gulmezoglu 2001, investigators appraised blood loss by collection with a fresh non-absorbent sheet and low plastic "fracture" bedpan placed under the mother from as soon as possible after delivery until 1 hour postpartum. Investigators considered that quote: "longer-term blood loss measurement is more difficult to standardise". They transferred the blood collected in the sheet and the bedpan (together with any soaked small gauze swabs) to a measuring jar to ascertain the volume. Alternatively, they collected blood with a plastic sheet placed under the mother immediately after delivery. If bleeding continued beyond 1 hour, investigators restarted collection and measurement until bleeding subsided. Attempts were made to minimise any losses on the drapes and gowns of delivery attendants. In addition, quote: "the placental interstices also contain maternal blood (about 9% of placental weight)." Because overestimations (amniotic fluid) and underestimations (blood loss) were likely to be distributed equally between the 2 study groups, and most would have occurred before the onset of measurement, the data were not corrected
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "Data for the primary outcome were not available for 4 of the 1103 women"
Selective reporting (reporting bias)	High risk	The prospectively registered protocol of the study (ClinicalTrials.gov NCT 00124540) lists some secondary outcomes different to those included the study report (≥ 1000 mL within the first hour only, transfusion, Hb < 8 g/dL 24 hours after delivery)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised

Hofmeyr 2011 (*Continued*)

Funding source	Low risk	The study was supported by funding from Gynuity Health Projects through a grant from the Bill and Melinda Gates Foundation (public funding)

Hoj 2005

Methods	2-arm placebo-controlled randomised trial
Participants	661 women were randomised in a community setting in Guinea-Bissau. The population comprised women of parity 3 or less, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	600 mcg of misoprostol administered sublingually versus placebo
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Using a list of random numbers.
Allocation concealment (selection bias)	Low risk	Used opaque envelopes that were consecutively-numbered and filled with the study drugs
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "Misoprostol and placebo tablets of identical form, size, colour, and packing were produced"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	After delivery of the baby and drainage of the amniotic fluid, investigators placed a clean plastic-lined absorbent drape under the mother. They changed the drape as many times as needed. The mother stayed

Hoj 2005 (*Continued*)

		on the drape or was asked to wear a pad over the next 60 minutes. All drapes and pads were weighed with an electronic scale and the known dry weights were subtracted in order to ascertain the volume of blood loss on the basis that 1 g is equivalent to 1 mL
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the Danish Society of Obstetrics and Gynaecology, the Illum Foundation, and the Danish International Development Agency (public funding)

Hong 2007

Methods	2-arm placebo-controlled randomised trial	
Participants	214 women were randomised in a hospital setting in Korea. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at high risk for PPH, who delivered by caesarean (unspecified whether elective or emergency). Exclusion criteria were not specified	
Interventions	20 IU of oxytocin administered by an IV infusion versus 400 mcg plus 20 IU of misoprostol plus oxytocin administered rectally plus by an IV infusion	
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; change in HB; fever; shivering	
Notes	Contact with study authors for additional information: yes. Additional data from authors: no	
Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**

Hong 2007 (*Continued*)

Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Placebo is mentioned but insufficient detail is reported to decide on blinding (of study participants and caregivers)
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Placebo is mentioned but insufficient detail is reported to decide on blinding of outcome assessors
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Humera 2016

Methods	2-arm active-controlled randomised trial
Participants	100 women were randomised in a hospital setting in India. The population comprised women of any parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with pre-eclampsia or eclampsia, previous caesarean, previous retained placenta, APH, coagulation disorder, cardiac diseases, diabetes, hypertension and epilepsy
Interventions	600 mcg of misoprostol administered orally versus 200 mcg of ergometrine administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); third stage duration (minutes); nausea.; vomiting; hypertension; headache; fever; shivering

Notes	Contact with study authors for additional information: no. Additional data from authors: no	
Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	After delivery of the baby amniotic fluid was allowed to drain away (if present) and amniotic fluid soaked bed linen covered with dry disposable linen saver, corrugated rubber sheet placed under buttocks, sterile kidney tray placed at the vulva was used to collect blood loss over next 1 hour. Collected blood was measured using a measuring jar, blood clots weighed separately (1 g = 1 mL). Blood soaked swabs were weighed, the known dry weight subtracted and the calculated volume added to that of the blood volume of measuring jar
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	No funding sought for this study.

Is 2012

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	400 mcg of misoprostol administered rectally versus unspecified of ergometrine administered IM
Outcomes	The study recorded the following outcomes: third stage duration (minutes); nausea; vomiting; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Jago 2007

Methods	2-arm active-controlled randomised trial
Participants	510 women were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing induction or augmentation of labour or instrumental delivery, or those requiring epidural analgesia or with hypertension in pregnancy, existing hypertension, chronic renal disease, diabetes, vascular diseases, cardiac disease, anticoagulation therapy or allergy to ergometrine or oxytocin
Interventions	500 mcg of ergometrine administered IM versus 10 IU of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; blood loss (mL) ; hypertension
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated list of random numbers.
Allocation concealment (selection bias)	Unclear risk	Used numbers that were labelled on envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were

Jago 2007 (*Continued*)

		randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Jangsten 2011

Methods	2-arm controlled randomised trial
Participants	1802 women were randomised in a hospital setting in Sweden. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing elective caesarean section, or those who were non-Swedish speaking or with previous PPH, pre-eclampsia, grand multiparity (more than 4) or intrauterine death
Interventions	10 IU of oxytocin administered by an IV bolus versus no treatment
Outcomes	The study recorded the following outcomes: PPH at 1000; transfusion; manual removal of placenta; blood loss (mL); change in Hb; third stage duration (minutes); maternal satisfaction
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated sequence.
Allocation concealment (selection bias)	Low risk	Used sealed envelopes containing the randomisation group prepared in consecutive order and kept in another unit. At randomisation, midwives phoned the staff at the other unit who opened the envelopes and disclosed the assigned intervention and trial number
Blinding of participants and personnel (performance bias) All outcomes	High risk	Quote: "Because of the nature of the study, blinding was not possible for the midwives, but the women were not informed of which management was to be used for them"
Blinding of outcome assessment (detection bias) All outcomes	High risk	Assessors were not blinded to treatment allocations.

Jangsten 2011 (*Continued*)

Objective assessment of blood loss	Low risk	Investigators appraised blood loss by removing pads soaked with amniotic fluid and placing a dry sanitary pad under the mother, immediately after the birth of the baby. They weighed all sanitary towels and pads before and after use. Blood loss was recorded (a) between the birth of the baby and the expulsion of the placenta, and (b) from expulsion of the placenta up to 2 hours postpartum
Incomplete outcome data (attrition bias) All outcomes	Low risk	171 randomised women were not included in the study analysis. Among those randomised to receive oxytocin, 4 withdrew consent, 75 had caesareans, and 14 were lost to follow up. In the control group, 2 withdrew consent, 56 had caesareans, and 20 were lost to follow up
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	The authors excluded 131 randomised study participants from the analysis because they experienced caesarean deliveries
Funding source	Low risk	The study was supported by funding from the Research and Development Board in Göteborg and Bohuslän, Baby Bag and the SU Foundation in Sweden (public funding)

Jans 2017

Methods	2-arm controlled randomised trial
Participants	1704 women were randomised in a community setting in the Netherlands. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with indications for a prophylactic approach to the third stage management in primary midwifery care and women with poor command of the Dutch language
Interventions	5 IU of oxytocin administered IM versus no treatment
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000.;additional uterotonics; transfusion; third stage duration (minutes); breastfeeding; nausea; vomiting; headache; abdominal pain; maternal well-being
Notes	Contact with study authors for additional information: yes. Additional data from authors: no
Risk of bias	

Jans 2017 (*Continued*)

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Randomisation was carried out by a lottery method Quote: "Randomization was achieved using two numbered and sealed opaque envelopes. Each envelope contained a sticker indicating one of the allotted treatments. When the midwife was confident that the birth would be completed in her care (defined for primigravid women when a large part of the baby's head was presenting and for multiparous women at the beginning of the second stage of labor), the woman herself or someone else designated by her would choose one of the two envelopes."
Allocation concealment (selection bias)	High risk	Allocation concealment was not reported but unlikely to have been implemented with a lottery method of randomisation
Blinding of participants and personnel (performance bias) All outcomes	High risk	Not blinded.
Blinding of outcome assessment (detection bias) All outcomes	High risk	Not blinded.
Objective assessment of blood loss	Low risk	Used digital scales, 10 disposable pre-weighed incontinence pads (a small impermeable multilayered sheet with high absorbency) and graduated measuring cups
Incomplete outcome data (attrition bias) All outcomes	Low risk	1704 women were randomised in the study, but 18 were excluded because of referral to hospital (n = 16) and were lost to follow-up or withdrew from the study (n = 2) after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The trial was funded by the Prevention Fund of the Netherlands

Jerbi 2007

Methods	2-arm controlled randomised trial
Participants	130 women were randomised in a hospital setting in Tunisia. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with placenta praevia, APH, non-cephalic presentation, intrauterine death, grand multiparity, (more than 5), fibroids, anticoagulation therapy, previous PPH or previous caesarean
Interventions	5 IU of oxytocin administered by an IV bolus versus no treatment
Outcomes	The study recorded the following outcomes: PPH at 1000; transfusion; manual removal of placenta; death; change in Hb; third stage duration (minutes)
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were unclear.

Jirakulsawas 2000

Methods	2-arm active-controlled randomised trial
Participants	140 women were randomised in a hospital setting in Thailand. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	600 mcg of misoprostol administered orally versus 200 mcg of ergometrine administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; blood loss (mL)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and care-givers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Kabir 2015

Methods	2-arm active-controlled randomised trial
Participants	110 women were randomised in a hospital setting in Bangladesh. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with placenta praevia, multiple pregnancy, placental abruption, hypertensive disorders, pre-eclampsia, cardiac/renal/liver disorders, epilepsy, moderate anaemia (Hb < 9 g/dLl), intrauterine fetal death and unwilling to participate in the study
Interventions	100 mcg of carbetocin administered by an IV bolus versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; blood loss (mL); abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Used a computer generated randomisation.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Used pre-weighted standardised delivery mat (Quaiyum's mat) and pre-weighted sanitary pads for blood collection after delivery to each of the pregnant woman to measure blood loss and measured the amount of blood loss in g by digital postal scale
Incomplete outcome data (attrition bias) All outcomes	High risk	110 women were randomised in the study, but 16 were excluded because of pre-eclampsia (n = 5), eclampsia (n = 5), placenta praevia (n = 2), placental abruption (n = 2) and multiple pregnancy (n = 2) after randomisation

Kabir 2015 (*Continued*)

Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Karkanis 2002

Methods	2-arm active-controlled randomised trial
Participants	238 women were randomised in a hospital setting in Canada. The population comprised women of parity 5 or less, unspecified whether singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with coagulopathy, anticoagulation therapy, previous PPH or previous caesarean
Interventions	400 mcg of misoprostol administered rectally versus 5 IU of oxytocin administered by an IV bolus or IM
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; manual removal of placenta; change in Hb; third stage duration (minutes); nausea; vomiting; headache; fever; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	A statistician developed blocked randomisation tables for each centre
Allocation concealment (selection bias)	Low risk	Pharmacy assembled consecutively-numbered opaque, sealed packets that contained the group allocation
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	High risk	Assessors were not blinded to treatment allocations.

Karkanis 2002 (*Continued*)

Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "13 women randomised subsequently delivered by caesarean and were excluded from analysis. 2 women were lost to follow-up early in the trial when their packets were opened but the manoeuvre was not completed and no data were recorded"
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Not all study participants were included in the analysis.
Funding source	Low risk	The study was supported by funding from the physicians of Ontario, through the Physician Services Incorporated Foundation (public funding)

Kerekes 1979

Methods	3-arm controlled randomised trial
Participants	140 women were randomised in a hospital setting in Hungary. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	200 mcg of ergometrine administered IV bolus versus no treatment
Outcomes	The study recorded the following outcomes: third stage duration (minutes)
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.

Kerekes 1979 (*Continued*)

Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Investigators appraised blood loss by collection in a container placed under the mother during the third stage of labour until 2 hours postpartum. The contents of the container were transferred to a measuring cylinder. However, blood loss data were not reported in a format that could be extracted for the purpose of this review
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Khan 1995

Methods	2-arm active-controlled double-blinded randomised trial
Participants	2040 women were randomised in a hospital setting in United Arab Emirates. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing induction or augmentation of labour, caesarean section or instrumental delivery, or requiring general anaesthesia, epidural or diazepam, or those with antenatal hypertension (160/100 mmHg or more), hypertension on antihypertensive drugs, multiple pregnancy, cardiac disease or Hb of 90 g/L or less
Interventions	10 IU of oxytocin administered IM versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; transfusion; manual removal of placenta; vomiting; headache

Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Number code by the hospital pharmacist who alone was aware of the content of the ampoules
Allocation concealment (selection bias)	Low risk	Participants were assigned an opaque sealed envelope. Each envelope carried the instruction to use a numbered vial of the study drug
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss "in the standard way" by measurement of blood and clots in a graduated jug, and by weighing swabs and linen
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "12 patients had to be excluded from the trial (oxytocin 5; ergometrine plus oxytocin 7) after randomisation because they no longer fulfilled the inclusion criteria (2 who required caesarean section and 10 who were delivered by forceps or ventouse (oxytocin, 4; Ergometrine plus oxytocin 6)."
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Khurshid 2010

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with hypertension, cardiac disease, renal disease, gastro-intestinal disorders, respiratory disease, endocrinal problems, coagulation disorder and sensitivity to prostaglandin or methergin
Interventions	125 mcg of carboprost administered IM versus 200 mcg of ergometrine administered by an IV bolus
Outcomes	The study recorded the following outcomes: additional uterotonics; manual removal of placenta; blood loss (mL;.third stage duration (minutes)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Randomisation was done using random tables.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Blood loss was estimated by collecting blood and blood clots in the kidney tray and adding the difference in the weight of the drapes before use and after birth
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised

Khurshid 2010 (*Continued*)

Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Koen 2016

Methods	2-arm active-controlled double-dummy randomised trial
Participants	540 women were randomised in a hospital setting in South Africa. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women not willing or not able to provide consent, previous classic CS, < 18 years of age, pre-eclampsia, eclampsia, uncontrolled hypertension, cardiac/liver/renal disorders, hypersensitivity to oxytocin or oxytocin + ergometrine, occlusive vascular disease, autoimmune vasculitis
Interventions	12.5 IU of oxytocin administered by an IV bolus + infusion versus 500 mcg plus 15 IU of ergometrine plus oxytocin administered IM plus by an IV infusion
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; blood loss (mL); nausea; vomiting; headache
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Quote: "Randomisation was carried out by a lottery method "Randomisation was by means of sealed not transparent envelopes. Each had a label inside with a letter A (oxytocin group) or B (oxytocin + ergometrine), which corresponded to a pair of pre-packed colour-coded ampoules that were used for the two different groups."
Allocation concealment (selection bias)	High risk	Quote: "Randomisation was carried out by a lottery method "Randomisation was by means of sealed not transparent envelopes. Each had a label inside with a letter A (oxytocin group) or B (oxytocin + ergometrine), which corresponded to a pair of pre-packed colour-coded ampoules that were used for the two different groups."

Koen 2016 (*Continued*)

Blinding of participants and personnel (performance bias) All outcomes	Low risk	Double-blinded.
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinded.
Objective assessment of blood loss	Low risk	Calculation of blood loss was done using calculated pregnancy preoperative blood volume (0.75 × [{height inches × 50} + {weight pounds × 25}) × percentage of blood volume lost ([pre-delivery haematocrits - post-delivery haematocrits]/pre-delivery haematocrits)
Incomplete outcome data (attrition bias) All outcomes	High risk	540 women were randomised in the study, but 124 were excluded because of giving birth vaginally (n = 80), incomplete data or protocol violations (n = 44) after randomisation
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered prospectively (ClinicalTrials.gov NCT02046499)
Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Kumar 2016

Methods	2-arm active-controlled randomised trial
Participants	201 women were randomised in a hospital setting in India. The population comprised women of any parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesareans, with hypersensitivity to drugs, asthma, cardiac diseases, epilepsy, psychiatric disorders, liver and renal diseases
Interventions	125 mcg of carboprost administered IM versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; transfusion; death; blood loss (mL); third stage duration (minutes); diarrhoea; nausea; vomiting; fever; shivering

Notes	Contact with study authors for additional information: no. Additional data from authors: no	
Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Low risk	Used sequentially-numbered sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Perineal drapes were replaced by calibrated Brasss V obstetric drape after the delivery of the baby. The average time taken for episiotomy suturing was around 10 minutes in both the groups and did not have any significant impact on the blood loss and duration of bleeding. Brasss V drape was removed 10 minutes after the episiotomy suturing in all patients unless the patient continued to have significant PPH
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	1 women was excluded because of a fourth degree tear after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Kumru 2005

Methods	2-arm active-controlled randomised trial
Participants	55 women were randomised in a hospital setting in Turkey. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women with multiple pregnancy, hypertension or vascular diseases
Interventions	10 IU of oxytocin administered by an IV bolus + infusion versus 200 mcg plus 10 IU of ergometrine plus oxytocin administered by an IV bolus plus by IV bolus plus infusion
Outcomes	The study recorded the following outcomes: blood loss (mL).
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and care-givers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised intraoperative blood loss by weighing compresses and rolls before and after the birth of the baby, and calculating the difference between these measurements. Pre-weighted pads were distributed in advance to each mother, and collected at intervals of 3-6 hours hour intervals after the aspiration of amniotic fluid
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated

Kumru 2005 (*Continued*)

		to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Kundodyiwa 2001

Methods	2-arm placebo-controlled randomised trial
Participants	500 women were randomised in a hospital setting in Zimbabwe. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing instrumental delivery, or those with previous PPH, antepartum haemorrhage, coagulopathy, multiple pregnancy, asthma or allergies to prostaglandins or oxytocin
Interventions	400 mcg of misoprostol administered orally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; severe maternal morbidity: intensive care admissions; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); third stage duration (minutes); diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated using a random sequence.
Allocation concealment (selection bias)	Low risk	The participant was asked to randomly pick a numbered sealed opaque envelope from the study cooler-box
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "Identical placebo tablets could not be obtained from the manufacturers. The tablets were similar in size and colour but not in shape. However, most reviewed trials on misoprostol had this similar problem although this method of blinding proved to be effective."
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Quote: "The data sheet was completed by the midwife supervising the delivery and collected and checked by the research assis-

Kundodyiwa 2001 (*Continued*)

		tant"
Objective assessment of blood loss	Low risk	After delivery, investigators appraised blood loss by removing linen soiled with amniotic fluid, and then placing a fresh disposable incontinence pad with a plastic backing under the mother. Blood expressed from the uterus was measured with a calibrated measuring jug. The volume of blood soiling linen savers and sanitary pads was determined as the difference between dry weights and soiled weights: these measurements were added to the volume recorded by the calibrated jug
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "Data for 1 woman were excluded because she delivered undiagnosed twins after randomisation"
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Kushtagi 2006

Methods	2-arm active-controlled randomised trial
Participants	215 women were randomised in a hospital setting in India. The population comprised women of any parity, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	200 mcg of ergometrine administered by an IV bolus versus 125 mcg of carboprost administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; blood loss (mL); third stage duration (minutes); hypertension
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Kushtagi 2006 (*Continued*)

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Amount of blood loss was quantified by noting the increment in weight of standardised tampons which were placed high up in the vagina immediately after placental delivery
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Lam 2004

Methods	2-arm active-controlled randomised trial
Participants	60 women were randomised in a hospital setting in China (Hong Kong SAR). The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing induction or augmentation of labour, or those with antepartum haemorrhage, anaemia, 2 or more surgical terminations, previous manual removal of placenta, previous PPH or previous third stage complications
Interventions	500 mcg plus 5 IU of ergometrine plus oxytocin administered by an IV bolus versus 600 mcg of misoprostol administered sublingually

Lam 2004 (*Continued*)

Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; manual removal of placenta; death; fever
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Allocated using a random number-generated table.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss during the third stage by visual estimation, and by objective measurement on the basis of a method previously described by Newton and colleagues. Whilst any blood clots were collected and measured with a jug, white linen was placed under the mother during delivery and subsequently processed for 15 minutes with sodium hydroxide solution in an automatic stomacher (laboratory blender), to achieve the formation of alkaline hematin. Quote: "The optical density at 550 nm of the alkaline hematin was measured by spectrophotometry and compared with that of a known volume of a sample of the patient's venous blood" to calculate the volume of blood loss
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Lam 2004 (*Continued*)

Intention to treat analysis	Unclear risk	It was unclear from the study report whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Lamont 2001

Methods	2-arm active-controlled randomised trial
Participants	529 women were randomised in a hospital setting in the UK. The population comprised women of both nulliparous and multiparous, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by both caesarean and vaginal delivery. Exclusion criteria comprised women with known sensitivity to either prostaglandins, ergometrine or oxytocin, had a history of asthma, glaucoma, raised intraocular pressure or were known to have cardiac, pulmonary, renal or hepatic disease, hypertension, sepsis or obliterative vascular disorders. Women were excluded if they were currently taking anticoagulant treatment or participating in other clinical trials
Interventions	250 mcg of carboprost administered IM versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; manual removal of placenta; blood loss (mL); diarrhoea; nausea; vomiting
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Not blinded.
Blinding of outcome assessment (detection bias) All outcomes	Low risk	The randomisation slips were contained in envelopes which were opened by a person not involved in the postpartum assessments who resealed the envelope and drew 1 mL

Lamont 2001 (*Continued*)

		of the appropriate medication into a syringe. The nature of the medication was not revealed and the resealed envelope was retained in the woman's notes. The medication was administered by a competent person other than the one who had opened the envelope and filled the syringe
Objective assessment of blood loss	Unclear risk	Blood loss was measured as accurately as possible, taking into consideration the liquor amnii and soiling of the surgical drapes
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	530 women were randomised in the study, but 1 was excluded because did not receive the allocated agent (carboprost) after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Lapaire 2006

Methods	2-arm active-controlled double-blinded randomised trial
Participants	56 women were randomised in a hospital setting in Switzerland. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women undergoing emergency caesarean section, or those with fetal distress, fetal malformations, pre-eclampsia, HELLP syndrome, coagulopathy, severe systemic disorders, an American Society of Anesthesiologists physical status of 3 or greater, severe asthma, previous myomectomy, pyrexia (more than 38.5C) or hypersensitivity to prostaglandins
Interventions	25 IU of oxytocin administered by an IV bolus + infusion versus 800 mcg plus 5 IU of misoprostol plus oxytocin administered orally plus by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; death; blood loss (mL); nausea; headache; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	The hospital pharmacy performed the 1: 1 computer-generated randomisation that assigned the participants to their group
Allocation concealment (selection bias)	Low risk	Used identical study boxes from pharmacy.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study was "double-blind": Quote: "the study drugs and placebos [were provided by the pharmacy] in unidentifiable form"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	When the membranes ruptured before delivery, investigators appraised intraoperative and postoperative blood loss by determining the difference in weight of cloths and pads used to absorb blood during surgery and in the intermediate care unit. When membranes did not rupture preoperatively, investigators appraised blood loss by collection in suction bottles and subtracting estimated amniotic fluid volume. Investigators considered that 1 g is equivalent to 1 mL of blood or amniotic fluid
Incomplete outcome data (attrition bias) All outcomes	High risk	Quote: "3 patients in the oxytocin group were excluded from statistical analysis because of errors in drug administration". Moreover calculated blood loss data were unavailable in 13 cases and for these women the primary outcome was estimated clinically."
Selective reporting (reporting bias)	High risk	The study protocol that was registered retrospectively (ClinicalTrials.gov) lists PPH as the primary outcome of the study, but the study report lists the primary outcomes as intraoperative and postoperative blood loss and drug-related adverse effects (these items are listed only as secondary outcomes in the registration file). The study does not report the incidence of PPH $\geq$ 500 mL,

Lapaire 2006 (*Continued*)

		nor PPH ≥ 1000 mL
Intention to treat analysis	High risk	The authors excluded 3 study participants in the oxytocin group from the analysis because they incurred errors in drug administration
Funding source	Low risk	The study was supported by funding from the Scientific Pool of Basel University Hospital (the institution of the authors)

Leung 2006

Methods	2-arm active-controlled double-dummy randomised trial
Participants	329 women were randomised in a hospital setting in Hong Kong. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women requiring prophylactic oxytocin infusion, or those with pre-existing hypertension, pre-eclampsia, asthma, cardiac/renal/liver diseases, grand multiparity or fibroids
Interventions	100 mcg of carbetocin administered IM versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); change in Hbl third stage duration (minutes); nausea; vomiting; hypertension; headache; tachycardia; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated code before the recruitment.
Allocation concealment (selection bias)	Low risk	This was performed by opening a sealed, consecutively-numbered, opaque envelope
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations

Leung 2006 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by visual estimation.
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "15 women in the carbetocin group and 14 women in the ergometrine plus oxytocin group failed to have a paired haemoglobin test to measure the change in haemoglobin 48 hours after delivery either because they had requested early home or refused further blood taking. These 29 women were excluded."
Selective reporting (reporting bias)	High risk	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of fever were omitted)
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	High risk	The study was supported by funding from Ferring Pharmaceuticals

Lokugamage 2001

Methods	2-arm active-controlled randomised trial
Participants	40 women were randomised in a hospital setting in UK. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women with two or more previous caesarean sections or previous uterine rupture
Interventions	10 IU of oxytocin administered by an IV bolus versus 500 mcg of misoprostol administered orally
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; blood loss (mL); change in Hb; fever;.shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no
Risk of bias	

Lokugamage 2001 (*Continued*)

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	The randomisation was undertaken by means of computer-generated random numbers
Allocation concealment (selection bias)	Low risk	Used sealed opaque envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Quote: "The obstetrician, surgical assistant, scrub nurse and recovery midwife were blinded to the treatment. The anaesthetist and the anaesthetic assistant were not blinded as it was important for patient safety that a record was kept of all drugs administered."
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised intraoperative and postoperative (up to 1 hour) blood loss by visual estimation, quote: "in a standard manner (volume of blood in suction bottle plus soiling of swabs and bed sheets)"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by "assistance" from the Department of Anaesthesia at University College London Hospitals NHS Trust (the institution of the authors)

Lumbiganon 1999

Methods	3-arm active-controlled double-dummy randomised trial
Participants	597 women were randomised in a hospital setting in South Africa and Thailand. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing elective caesarean section or abortion, or those with asthma, other severe chronic allergic conditions a contraindication to use of misoprostol or if they were not willing or able to give informed consent
Interventions	600 mcg or 400 mcg of misoprostol administered orally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Random allocation sequence, generated centrally.
Allocation concealment (selection bias)	Low risk	The treatment packs were consecutively-numbered and sealed.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The packs were identical in shape, colour, weight and feel. Each woman received an injection and 3 tablets. Thus, the trial was double-blinded using double placebos"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss from the delivery of the baby until the mother was transferred to postnatal care. The collected blood was poured into a standard measuring jar provided by WHO for the purpose of volumetric measurement. Linen was not weighed but clots and small gauze swabs soaked with blood were included in the measurement

Lumbiganon 1999 (*Continued*)

Incomplete outcome data (attrition bias) All outcomes	Low risk	Exclusion after randomisation: 8 women in the oxytocin group did not comply with treatment (6 had an emergency caesarean section, 1 was HIV positive and mistakenly excluded, 1 whose ampoule was not located). 1 woman in the 600 mcg group was excluded
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the WHO (public funding). Active and placebo medications, syringes and swabs were donated by Searle, Novartis Pharma AG and Becton Dickinson International

Maged 2016

Methods	2-arm active-controlled double-blinded randomised trial
Participants	200 women were randomised in a hospital setting in Egypt. The population comprised women of any parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with placenta praevia, coagulopathy, pre-eclampsia, cardiac/renal/liver disorders, epilepsy or known hypersensitivity to oxytocin or carbetocin
Interventions	100 mcg of carbetocin administered IM versus 5 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion.; blood loss (mL); change in Hb; third stage duration (minutes) ; nausea; vomiting; headache; tachycardia; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Participants were equally randomised using automated web-based randomisation system

Maged 2016 (*Continued*)

Allocation concealment (selection bias)	Unclear risk	Only states that ensured allocation concealment with no further details
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported in sufficient detail even though the authors state it was double-blinded
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by weighing swabs and using pictorial charts
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Maged 2017

Methods	2-arm active-controlled double-blinded randomised trial
Participants	300 women were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women with placenta previa, coagulopathy, pre-eclamptic or known sensitivity to oxytocin or methergine
Interventions	100 mcg of carbetocin administered by an IV bolus versus 200 mcg plus 5 IU of ergometrine plus oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 1000; additional uterotonics; blood loss (mL; change in Hb; nausea; vomiting; headache; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Maged 2017 (*Continued*)

Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomised using automated web based randomisation system.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported in sufficient detail
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	The authors state the study was double-blinded but blinding (of study participants and caregivers) was not described in sufficient detail
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Calculated estimated blood loss.
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Malik 2018

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with anaemia, pregnancy-induced hypertension, placental abruption/placenta praevia, multiple pregnancy, grand multiparous, malpresentation, polyhydramnios, previous uterine scar, chorioamnionitis, prolonged labour, intrauterine fetal death, coagulation disorder, asthma/epilepsy/heart/renal disorder

Interventions	125 mcg of carboprost administered IM versus 200 mcg of ergometrine administered by an IV bolus
Outcomes	The study recorded the following outcomes: blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Amount of blood loss was calculated by weighing the gauzes/sponges before delivery followed by again weighing them after delivery
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Mannaerts 2018

Methods	2-arm active-controlled double-blinded randomised trial
Participants	68 women were randomised in a hospital setting in Belgium. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with medical conditions potentially influencing outcome measures (nausea, vomitus, and hypotension): diabetes, preexisting hypertension, pre-eclampsia, gestational hypertension, and known gastrointestinal diseases
Interventions	15 IU of oxytocin administered by an IV bolus + infusion versus 100 mcg of carbetocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: additional uterotonics; change in Hb; nausea
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Participants are randomly assigned following simple randomisation procedure in 1 : 1 ratio to 1 of the 2 treatment groups. A computer-generated randomisation list was generated using SPSS21
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Medication was prepared by a midwife not treating the patient to make sure that patient, gynaecologist, anaesthesiologist, and midwife clinically in charge of the patient are blinded for the medication
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Medication was prepared by a midwife not treating the patient to make sure that patient, gynaecologist, anaesthesiologist, and midwife clinically in charge of the patient are blinded for the medication
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	High risk	68 women were randomised in the study, but 10 were excluded because of incomplete data after randomisation

Mannaerts 2018 (*Continued*)

Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered prospectively (ISRCTN 95504420)
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

McDonald 1993

Methods	2-arm active-controlled double-blinded randomised trial
Participants	3497 women were randomised in a hospital setting in Australia. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing emergency or elective caesarean section, or requiring general anaesthetic for instrumental delivery, or those with hypertension in labour (more than 150/100 mm Hg), antenatal hypertension, maternal distress, advanced stage in labour, language barrier, fetal abnormality, intrauterine death or medical disorder
Interventions	500 mcg plus 5 IU of ergometrine plus oxytocin administered IM versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; NNU admissions; breastfeeding; nausea; vomiting
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	The ampoules were numbered by Sandoz by using simple randomisation. There was no blocking or prognostic stratification
Allocation concealment (selection bias)	Low risk	The ampoules were numbered by third party (Sandoz).

McDonald 1993 (*Continued*)

Blinding of participants and personnel (performance bias) All outcomes	Low risk	Delivery attendants were blinded to treatment allocations.
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending obstetricians and midwives
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "All women allocated to receive a drug were included in that group, excluding only the 14 women for whom drug allocation was not recorded"
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	High risk	The study was supported by funding from Sandoz.

Mitchell 1993

Methods	2-arm active-controlled double-blinded randomised trial
Participants	461 women were randomised in a hospital setting in the UK. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing elective caesarean section, or those with significant hypertension or cardiac disease
Interventions	500 mcg plus 5 IU of ergometrine plus oxytocin administered IM versus 5 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; manual removal of placenta; blood loss (mL); third stage duration (minutes)
Notes	Contact with study authors for additional information: yes. Additional data from authors: no
Risk of bias	

Mitchell 1993 (*Continued*)

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Unclear sequence: described as without any blocking or stratification
Allocation concealment (selection bias)	Low risk	Used identical study boxes prepared by third party (Sandoz).
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss quote: "in the standard way by graduated jug measurement plus an allowance for spillage"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the Perinatal Trials Service (public funding) , for the Department of Health for England and Wales, and for Birthright (the charitable arm of the RCOG). Coded medication ampoules were provided by Sandoz

Mobeen 2011

Methods	2-arm placebo-controlled randomised trial
Participants	1119 women were randomised in a community setting in Pakistan. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with hypertension, non-cephalic presentation, polyhydramnios, previous caesarean, multiple pregnancy, intrauterine death, antepartum haemorrhage or Hb less than 80 g/L

Interventions	600 mcg of misoprostol administered orally versus placebo
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; nausea; vomiting; headache; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	A computer-generated random code in blocks of 6 was maintained by Gynuity Health Projects in New York and not revealed until data collection and cleaning were completed
Allocation concealment (selection bias)	Low risk	Study medication was packed in numbered colour-coded boxes by Gynuity Health Projects in New York
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "Both women and TBAs were blinded to study assignment"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	To appraise postpartum blood loss, blood was collected with a perineal sheet and bedpan placed under the mother for a minimum of 1 hour or until active bleeding stopped (whichever occurred last). Quote: "Blood collected in the bedpan was transferred to a measuring jar, which was then closed, and the perineal sheet and cotton roll were placed in a sealed plastic bag. The closed measuring jar and sealed plastic bag were then placed inside a plastic cooler which was tightly closed and stored in a secure place in the woman's home until the local health visitor or community health nurse arrived for weighing, 1-2 days after delivery"

Mobeen 2011 (*Continued*)

Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "Invalid blood loss measures, which mainly occurred when monitoring visits were not possible because of poor weather conditions, were excluded from our analysis"
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered (ClinicalTrials.gov NCT00120237)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the Bill and Melinda Gates Foundation (public funding)

Modi 2014

Methods	4-arm active-controlled randomised trial
Participants	100 women were randomised in a hospital setting in India. The population comprised women of parity 3 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with gestations less than 37 or more than 42 weeks, intrauterine death, fetal growth restriction, hypertensive or cardiac or renal disorders, multiple pregnancies, placenta praevia, placenta abruption, grand multiparous, coagulation disorders, anaemia (< 8 g/dL), tachycardia or hypotension, malpresentations, chorioamnionitis, or known allergy to prostaglandins
Interventions	10 IU of oxytocin administered IM versus 200 mcg of ergometrine administered by an IV bolus versus 125 mcg of carboprost administered IM versus 600 mcg of misoprostol administered rectally
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; Blood loss (mL); third stage duration (minutes)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.

Modi 2014 (*Continued*)

Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Used BRASS-V drapes to measure the blood loss.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	No funding sought for this study.

Moertl 2011

Methods	2-arm active-controlled double-blinded randomised trial
Participants	84 women were randomised in a hospital setting in Austria. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women requiring general anaesthesia, or those with placenta praevia, placental abruption, multiple pregnancy, pre-eclampsia, gestational diabetes, pre-existing insulin-dependent diabetes, cardiovascular/renal disorders, hypo-/hyperthyroidism or women on cardiovascular system medications
Interventions	100 mcg of carbetocin administered by an IV bolus versus 5 IU of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: additional uterotonics change in Hb; nausea; headache
Notes	Contact with study authors for additional information: yes. Additional data from authors: no
Risk of bias	

Moertl 2011 (*Continued*)

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Randomisation was performed by a computer-generated randomisation sequence 1:1 ratio-blocks of 10 without stratification
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "Study medication was double-blinded to the clinical staff (obstetricians as well as anaesthesiologists) and the technicians performing the measurements"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators did not appraise blood loss.
Incomplete outcome data (attrition bias) All outcomes	High risk	After randomisation, investigators excluded 28 women from analysis for technical problems (n = 15), change to general anaesthesia (n = 9), recording artefacts (n = 3) and patient withdrawal (n = 1)
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered (EudraCT 2007-005498-78)
Intention to treat analysis	High risk	Not all study participants were included in the analysis.
Funding source	Low risk	CNSystems Medizintechnik AG in Graz, Austria provided the Task Force® Monitor 3040i system used to measure haemodynamic parameters. No other external funding was required for the study

Mohamed 2015

Methods	2-arm active-controlled randomised trial
Participants	172 women were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with medical disorder as hypertension, diabetes or on an anticoagulant, severe polyhydramnios, multiple pregnancy, placenta praevia or placental abruption, previous uterine scar other than lower segment caesarean section or who had more than 1 previous section

Interventions	5 IU of oxytocin administered by an IV bolus versus 100 mcg of carbetocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: blood loss (mL).
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was performed by computer generated randomisation system
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	After delivery of the placenta, the volume of blood loss was assessed by weight or saturation assessment techniques by subtracting the dry weight of absorbing materials (pads, sponges, etc) from the weight of blood-containing materials and using the conversion 1 g weight = 1 mL to quantify the blood volume contained in the materials
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Moir 1979

Methods	2-arm active-controlled randomised trial
Participants	88 women were randomised in a hospital setting in the UK. The population comprised women of primigravidas, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	500 mcg of ergometrine administered by an IV bolus versus 10 IU of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; blood loss (mL) ; nausea
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by quote: "the haemoglobin extraction-dilution technique, which is acceptably accurate (Roe, Gardiner and Dudley, 1962; Thornton et al, 1963) and particularly suited to obstetric use (Moir and Wallace, 1967; Wallace, 1967). The perdometer apparatus was used and all blood and blood-stained linen were collected"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Moir 1979 (*Continued*)

Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Moodie 1976

Methods	2-arm active-controlled randomised trial
Participants	148 women were randomised in a hospital setting in the UK. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	500 mcg of ergometrine administered by an IV bolus versus 5 IU of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; blood loss (mL); nausea
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with the placenta bowl and soiled linen and swabs. Quote: "The principles of the haemoglobin extraction-dilution technique employed have been discussed by Roe, Gardiner and Dudley (1962) and Thornton and colleagues (1963)

Moodie 1976 (*Continued*)

Incomplete outcome data (attrition bias) All outcomes	High risk	There were 148 study participants but blood loss data were available in only 80 cases
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Mukta 2013

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of any parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing emergency or elective caesarean section, or those with eclampsia, asthma, epilepsy, cardiac/kidney disorder or coagulopathy
Interventions	600 mcg of misoprostol administered orally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; diarrhoea; nausea; vomiting; fever; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Randomly divided into 2 equal groups.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.

Mukta 2013 (*Continued*)

Objective assessment of blood loss	Unclear risk	Investigators appraised blood loss in mL, by collection with a calibrated plastic drape, after the drainage of amniotic fluid and delivery of the baby until the third stage of labour was completed
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Musa 2015

Methods	2-arm active-controlled double-dummy randomised trial
Participants	235 women were randomised in a hospital setting in Nigeria. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing planned instrumental, or those who received oxytocin and/or misoprostol other than in the third stage of labour, or those with grand multiparity (more than 4), multiple pregnancy, fibroids, polyhydramnios, pre-eclampsia, eclampsia, hypertension, cardiac disorder, asthma,APH, previous PPH, prolonged rupture of membranes or Hb less than 100 g/L)
Interventions	600 mcg of misoprostol administered orally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; severe maternal morbidity: intensive care admissions; additional uterotonics; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**

Musa 2015 (*Continued*)

Random sequence generation (selection bias)	Low risk	Allocation was done by blocked (restrictive), using computer-generated random numbers prepared by an independent statistician
Allocation concealment (selection bias)	Unclear risk	Used opaque envelopes but no other details provided.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "Participants, caregivers, and outcome assessors (researchers or research assistants) were masked to group allocation. Investigators were not masked for data analysis"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Quote: "Participants, caregivers, and outcome assessors (researchers or research assistants) were masked to group allocation. Investigators were not masked for data analysis"
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by quote: "the gravimetric method" (Ambardekar 2009) until 1 hour after delivery
Incomplete outcome data (attrition bias) All outcomes	High risk	235 study participants were randomised but only 200 were analysed due to protocol deviations and missing data
Selective reporting (reporting bias)	Unclear risk	The study protocol was registered retrospectively (PACTR 201407000825227)
Intention to treat analysis	High risk	Not all study participants were included in the analysis.
Funding source	Low risk	The study was supported by funding from the University of Ilorin Teaching Hospital (the institution of the authors)

Nankaly 2016

Methods	3-arm active-controlled randomised trial
Participants	185 women were randomised in a hospital setting in Iran. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women with anaemia, multiple pregnancy, polyhydramnios, prolonged labour, PROM, placenta praevia, placental abruption, vaginal bleeding, diabetes, blood pressure, kidney disease, cardiovascular disease and coagulation disorders or other underlying disease

Interventions	20 IU of oxytocin administered by an IV infusion versus 400 mcg or 200 mcg of misoprostol administered sublingually
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported in Quote: "The randomisation was done via block randomisation and in the form of four blocks"
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Not blinded.
Blinding of outcome assessment (detection bias) All outcomes	High risk	Not blinded.
Objective assessment of blood loss	Unclear risk	Lost blood volume gained from calculating the total collected blood in suction container and counting the number of blood gases
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Nasr 2009

Methods	2-arm active-controlled double-dummy randomised trial
Participants	514 women were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with antepartum haemorrhage, coagulopathy, hypertension in pregnancy or the need for anticoagulants
Interventions	800 mcg of misoprostol administered rectally versus 5 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; severe maternal morbidity: intensive care admissions; additional uterotonics; transfusion; manual removal of placenta; death; third stage duration (minutes); diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Allocated by a computer-generated random allocation system created at the Statistics Unit of Assiut University Hospital
Allocation concealment (selection bias)	Low risk	Allocation codes were placed in sealed, opaque, consecutively-numbered envelopes
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study was quote: "double-blind": active treatments and placebo treatments were "identical-looking"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Nasr 2009 (*Continued*)

Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were unclear.

Nayak 2017

Methods	2-arm placebo-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women having severe medical and surgical complications including the heart, liver, kidney, brain disease and blood disorders, any contraindication to misoprostol including mitral stenosis, glaucoma and diastolic blood pressure over 100 mmHg and known allergic to prostaglandins, history of thromboembolic disorders, abnormal placentation such as placenta praevia, placental abruption and placental adhesions caused by repeated artificial abortions, pregnancy complications such as severe pre-eclampsia, multiple pregnancies, macrosomia and polyhydramnios, complication with myoma and with any blood dyscrasia
Interventions	400 mcg plus 10 IU of misoprostol plus oxytocin administered sublingually plus by an IV infusion versus 10 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; transfusion; blood loss (mL); change in Hb
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.

Nayak 2017 (*Continued*)

Objective assessment of blood loss	Low risk	The quantity of blood (mL) = (weight of (used material + unused material) after surgery-weight of all materials prior to surgery)/1.05 plus the volume included in the suction container after placental delivery. In addition, pads used after completion of caesarean section to 2 hours postpartum weighed
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Nellore 2006

Methods	2-arm active-controlled randomised trial
Participants	120 women were randomised in a hospital setting in India. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women requiring oxytocin induction or augmentation of labor, caesarean delivery, or those with gestational age less than 37 weeks, multiple pregnancy, Hb concentration less than 8 g/dL, and known allergy to prostaglandins
Interventions	400 mcg of misoprostol administered rectally versus 125 mcg of carboprost administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); change in Hb; third stage duration (minutes); shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**

Nellore 2006 (*Continued*)

Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and care-givers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any in-complete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Ng 2001

Methods	2-arm active-controlled randomised trial
Participants	2058 women were randomised in a hospital setting in Hong Kong. The population comprised women of parity 3 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women requiring oxytocin infusion in the third stage, or those with pre-eclampsia, cardiac disorder, asthma, grand multiparity (more than 3), fibroids or contraindications for the use of either misoprostol or syntometrine
Interventions	600 mcg of misoprostol administered orally versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death. Blood loss (mL); change in Hb; nausea; vomiting; hypertension; headache; fever; shivering

Ng 2001 (*Continued*)

Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Randomisation based on a table of computer-generated blocks of random numbers
Allocation concealment (selection bias)	Low risk	Consecutively-numbered opaque sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Quote: "This was not a double-blinded study".
Blinding of outcome assessment (detection bias) All outcomes	High risk	Assessors were not blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Ng 2004

Methods	2-arm active-controlled double-dummy randomised trial
Participants	298 women were randomised in an unspecified setting in Hong Kong. The population comprised women of unspecified parity, a singleton pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with multiple pregnancy or non-vaginal delivery

Ng 2004 (*Continued*)

Interventions	400 mcg of misoprostol administered orally versus 1 mL of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: (No outcome data found)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Double-blinding of personnel and participants (placebo use) but insufficient details from abstract only
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Ng 2007

Methods	2-arm active-controlled double-dummy randomised trial
Participants	360 women were randomised in a hospital setting in Hong Kong. The population comprised women of parity 3 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women requiring oxytocin infusion in the third stage, or those with pre-eclampsia, cardiac disorder, asthma, grand multiparity (more than 3), fibroids or contraindications for the use of either misoprostol or syntometrine
Interventions	400 mcg of misoprostol administered orally versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); change in Hb; diarrhoea; nausea; vomiting; hypertension; headache; fever; shivering; maternal satisfaction
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	The randomisation was based on a table of computer-generated random numbers
Allocation concealment (selection bias)	Low risk	Used consecutively-numbered and sealed opaque packages.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The placebo was identical in size and colour but had a different shape to the misoprostol tablet. All women were asked to swallow the tablets directly from the opaque cup without looking at them. The identity of the active medication and placebo were concealed from the caregivers and the parturient."
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "5 women were excluded from the analysis because of missing post-delivery haemoglobin level"

Ng 2007 (*Continued*)

Selective reporting (reporting bias)	High risk	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of tachycardia and dizziness were omitted)
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Nirmala 2009

Methods	2-arm active-controlled randomised trial
Participants	120 women were randomised in a hospital setting in Malaysia. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women younger than 18 years old, or those with cardiac disorder, hypertension requiring treatment, liver/renal/vascular/endocrine disorder (excluding gestational diabetes) or hypersensitivity to oxytocin or carbetocin
Interventions	100 mcg of carbetocin administered IM versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; severe maternal morbidity: intensive care admissions; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; nausea; vomiting; hypertension; headache; shivering; abdominal pain
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated randomisation.
Allocation concealment (selection bias)	Unclear risk	Used sealed, sequentially-numbered envelopes.

Nirmala 2009 (*Continued*)

Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Quote: "The preparation and administration of the medication was carried out by midwives who were not involved in the management of the patient except for the drug administration"
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by "the gravimetric method" from immediately after drug administration. They used a digital scale (Soehnle, Venezia) for weight measurement. In order to minimise confounding by fluid absorbed into drapes, they collected blood with a new plastic sheet placed under the mother after delivery of the baby. They also weighed any gauzes, tampons and pads used in the first hour after delivery of the placenta, and subtracted the dry weights of these materials to calculate blood loss on the basis that 1 g is equivalent to 1 mL
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Nordstrom 1997

Methods	2-arm placebo-controlled randomised trial
Participants	1000 women were randomised in a hospital setting in Sweden. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	10 IU of oxytocin administered by an IV bolus versus placebo

Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated randomisation.
Allocation concealment (selection bias)	Low risk	Ampoules were prepared at the hospital pharmacy and consecutively-numbered
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The content of the ampoules was unknown to mothers, midwives and doctors until the study was completed"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss quote: "by measuring collected blood and adding what was estimated to have been absorbed by surgical cloths and tissues"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the County Council and County Health Authority Research and Development Foundation in the County of Jämtland, Sweden (public funding)

Nuamsiri 2016

Methods	2-arm placebo-controlled randomised trial
Participants	323 women were randomised in a hospital setting in Thailand. The population comprised women of parity 4 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with multiple pregnancy, polyhydramnios, uterine fibroids, previous PPH, APH, parity greater than 4, previous caesarean section, severe anaemia (Hb level of $\leq$ 8 g/dL), coagulopathy, contraindications to the use of ergometrine, estimated fetal birthweight > 4000 g. and inability to obtain written informed consent. Women who ended up having a caesarean section or instrumental delivery were also excluded from this study
Interventions	200 mcg plus 20 IU of ergometrine plus oxytocin administered by an IV bolus + infusion versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; death; blood loss (mL); change in Hb; third stage duration (minutes); nausea; hypertension
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Random allocation scheme using a computer-generated list of numbers
Allocation concealment (selection bias)	Low risk	Used sealed and consecutively numbered opaque envelopes were prepared by a research assistant not involved in the study. The women were randomly allocated to 1 of the 2 study groups by opening the next available envelope just before delivery
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study drug and placebo were prepared by the research assistant not involved in the study. The obstetrician and nursing staff were all blinded to the type of injectable substance
Blinding of outcome assessment (detection bias) All outcomes	Low risk	The study drug and placebo were prepared by the research assistant not involved in the study. The obstetrician and nursing staff were all blinded to the type of injectable substance
Objective assessment of blood loss	Low risk	Used the blood collection drape, which was placed under the buttocks after placental

Nuamsiri 2016 (*Continued*)

		delivery. Blood-soaked swabs were weighed in grams, and the known dry weight of the swabs was subtracted, this volume was added to the measured blood volume from the drape (assuming an equivalence of 1 g to 1 mL)
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The study report matches the study protocol that was registered retrospectively (TCTR20150820001)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding were not reported.

Oboro 2003

Methods	2-arm active-controlled double-dummy randomised trial
Participants	496 women were randomised in a hospital setting in Nigeria. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing induction or augmentation of labour, or those with previous caesarean, Hb less than 80 g/L, previous PPH, grand multiparity (not defined), multiple pregnancy, polyhydramnios, fibroids or precipitate labour
Interventions	10 IU of oxytocin administered IM versus 600 mcg of misoprostol administered orally
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Generated by using random tables.

Oboro 2003 (*Continued*)

Allocation concealment (selection bias)	Low risk	Pharmacy prepared opaque sealed sequentially-numbered packets
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The identity of the active medication and placebo were concealed from the caregivers and women"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending obstetricians
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Ogunbode 1979

Methods	3-arm active-controlled randomised trial
Participants	144 women were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing instrumental delivery, or those with previous PPH, multiple pregnancy, polyhydramnios or vaginal lacerations
Interventions	200 mcg or 500 mcg of ergometrine administered IM versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; manual removal of placenta; blood loss (mL)
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Ogunbode 1979 (*Continued*)

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Restricted random allocation.
Allocation concealment (selection bias)	Unclear risk	Used sealed sequentially-numbered envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Quote: "The identity of the various drugs was not known to the investigators until after completion of the trial"
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by collection in a dish pressed against the vulva for 3 minutes: the contents were carefully measured
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	High risk	The study was supported by funding from Sandoz.

Orji 2008

Methods	2-arm active-controlled randomised trial
Participants	600 women were randomised in a hospital setting in Nigeria. The population comprised women of parity 6 or less, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with hypertension in pregnancy, packed cell volume less than 30%, previous PPH, haemoglobinopathy or cardiac disorder
Interventions	10 IU of oxytocin administered by an IV bolus versus 250 mcg of ergometrine administered by an IV bolus

Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; manual removal of placenta. Blood loss (mL); change in Hb; third stage duration (minutes); nausea; vomiting; hypertension; headache
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation was done by sealed sequentially-numbered envelopes
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and care-givers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Investigators appraised blood loss by "using a pre-weighed gauze that was weighed again after delivery"
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any in-complete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification, but not all of the outcomes pro-jected by methodological descriptions were reported as results in the study report (cases of transfusion and PPH $\geq$ 1000 mL were omitted)
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Ortiz-Gomez 2013

Methods	3-arm active-controlled randomised trial
Participants	156 women were randomised in a hospital setting in Spain. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with comorbidities, refractory hypotension due to neuraxial blockage, vasoactive drugs needed to control haemodynamic issues or multiple pregnancy
Interventions	100 mcg of carbetocin administered by an IV bolus versus 61 IU of oxytocin administered by an IV bolus + infusion
Outcomes	The study recorded the following outcomes: additional uterotonics; nausea; vomiting; headache; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated sequence.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Investigators appraised blood loss by the estimation of delivery attendants, but blood loss data were not reported in a format that could be extracted for the purpose of this review
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in

Ortiz-Gomez 2013 (*Continued*)

		the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Othman 2016

Methods	2-arm active-controlled randomised trial
Participants	120 women were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with anaemia (Hb < 8 g/dL), multiple pregnancy, placental abnormality (e.g. placenta praevia, placenta abruption), polyhydramnios, 2 or more previous caesarean deliveries, current or previous history of heart disease, liver, renal disorders or known coagulopathy
Interventions	400 mcg of misoprostol administered sublingually versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: additional uterotonics; blood loss (mL); vomiting; headache; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was done using a computer-generated random table
Allocation concealment (selection bias)	Low risk	Quote: "Allocation concealment was done using serially numbered closed opaque envelopes. Each envelope was labelled with a serial number and had a card noting the intervention type inside. Allocation was never changed after opening the envelopes."
Blinding of participants and personnel (performance bias) All outcomes	High risk	Not blinded.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.

Othman 2016 (*Continued*)

Objective assessment of blood loss	Low risk	Quote: "The volume of blood loss during caesarean delivery and 2 hours postoperatively was assessed. Total blood loss during caesarean delivery was measured by adding the volume of the suction bottle with the blood soaked sponges (know dry weight) . Blood loss 2 hours after caesarean delivery was measured by using blood collection drape. The whole blood loss was estimated by adding the blood in the suction bottle, blood soaked sponges and blood collection drape."
Incomplete outcome data (attrition bias) All outcomes	Low risk	120 women were randomised in the study, but 10 were excluded from the analysis from the oxytocin group after randomisation
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered prospectively (NCT02562300)
Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Owonikoko 2011

Methods	2-arm active-controlled randomised trial
Participants	100 women were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women requiring general anaesthesia, or those with multiple pregnancy, placenta praevia, antepartum haemorrhage, cardiac/renal/liver disorders, coagulopathy, asthma, glaucoma, pre-eclampsia, eclampsia, prolonged labour or contraindications to administration of prostaglandins
Interventions	20 IU of oxytocin administered by an IV infusion versus 400 mcg of misoprostol administered sublingually
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; blood loss (mL); nausea; vomiting; headache; hypotension; shivering

Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Allocation sequence was developed by a statistician who was not otherwise involved with the study using computer-generated table of random numbers and varied permutated blocks
Allocation concealment (selection bias)	Low risk	Used sealed, opaque envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Quote: "The anaesthetist was blind to the allocation until he opened each participant's envelope at surgery. The obstetricians were unaware of what oxytocic was given as the faces of the patients were screened off during the surgery"
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Quote: "The obstetricians were unaware of what oxytocic was given as the faces of the patients were screened off during the surgery"
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection in a suction bottle, and by weighing delivery drapes and gauzes on the basis that 1 g is equivalent to 1 mL of blood. Quote: "Both the surgeon and anaesthetist estimated blood loss independently. The scrub nurse weighed the drapes and gauze before and after the operation, noted the amount of blood in the suction bottle, and recorded these. The postoperative care nurse also recorded the blood loss during the first 4 hours after surgery". Finally a research assistant (not part of the medical team) calculated the mean estimated blood loss from all these values
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Owonikoko 2011 (*Continued*)

Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Pakniat 2015

Methods	3-arm active-controlled double-dummy randomised trial
Participants	150 women were randomised in a hospital setting in Iran. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women with any risk factor of postpartum haemorrhage i.e. anaemia (Hb < 8 g/dL), multiple pregnancy, antepartum haemorrhage, polyhydramnios, 2 or more previous caesarean sections and/or a history of previous uterine rupture, cardiac/liver/renal disorders, or known coagulopathy
Interventions	400 mcg of misoprostol administered sublingually versus 200 mcg plus 5 IU of misoprostol plus oxytocin administered sublingually plus by an IV bolus versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: additional uterotonics; change in Hb; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	The study is stated to be double-blinded but blinding (of study participants and caregivers) was unclear. The study used dummy infusion and tablets but there was no mention of a dummy for the IV bolus that 1 of the groups received. There is insufficient detail reported to decide on the adequacy of the blinding

Pakniat 2015 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	The volume of blood in the suction bottle and blood-soaked sponges was measured
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered prospectively (NCT01571323)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Parsons 2006

Methods	2-arm active-controlled randomised trial
Participants	450 women were randomised in a hospital setting in Ghana. The population comprised women of both nulliparous and multiparous, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with asthma, epilepsy or contraindications to prostaglandins
Interventions	10 IU of oxytocin administered IM versus 800 mcg of misoprostol administered orally
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; nausea; vomiting; hypertension; fever;. shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated allocation.

Parsons 2006 (*Continued*)

Allocation concealment (selection bias)	Low risk	Used sequentially-numbered, opaque, sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Quote: "We acknowledge that unblinding for some participants was possible because the envelopes for women who were initially randomised but who subsequently underwent caesarean section were returned and used for the next women enrolled"
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians and midwives
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from Matercare International and the Society of Obstetricians and Gynaecologists of Canada (public funding)

Parsons 2007

Methods	2-arm active-controlled randomised trial
Participants	450 women were randomised in a hospital setting in Ghana. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with asthma, epilepsy or contraindications to prostaglandins
Interventions	10 IU of oxytocin administered IM versus 800 mcg of misoprostol administered rectally
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes); nausea; vomiting; hypertension; fever; shivering

Parsons 2007 (*Continued*)

Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Low risk	Used sequentially-numbered, opaque, sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Quote: "Unblinding for some participants was possible because the envelopes for women who were initially randomised but who subsequently underwent caesarean section were returned and used for the next women enrolled"
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians and midwives
Incomplete outcome data (attrition bias) All outcomes	Low risk	Estimated blood loss data were unavailable in 9 cases (misoprostol 7; oxytocin 2) and haemoglobin measurements (misoprostol 4; oxytocin 6) were unavailable in 10 cases
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from Matercare International and the Society of Obstetricians and Gynaecologists of Canada (public funding)

Patil 2013

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with Hb level less than 7 g/dL, APH, multiple pregnancy, non-cephalic presentations, pregnancy induced hypertension, previous LSCS, induced labour, instrumental delivery, cervical tear and third-degree perineal tear, body temperature > 38^{o} C on admission, cardiac disease, hepatic disorders and known hypersensitivity to prostaglandins
Interventions	600 mcg of misoprostol administered orally versus 200 mcg of ergometrine administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; blood loss (mL); diarrhoea; nausea; vomiting; headache; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	A computer-generated randomisation table was used to randomise participants
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and care-givers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Once the active bleeding stopped, collected blood was weighed. Swabs and pads used during 3rd stage were not counted for blood loss, but were kept to minimum of < 3
Incomplete outcome data (attrition bias) All outcomes	Low risk	200 women were randomised in the study, but 2 were excluded because of third degree perineal tear (n = 1) and adherent placenta (n = 1) after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Patil 2013 (*Continued*)

Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Patil 2016

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of parity 4 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with hypersensitivity to drugs, respiratory diseases, cardiac disease, renal, liver disorder, epilepsy, psychiatric disorders, pre-eclampsia, severe anaemia, multiple pregnancy, poly/oligohydramnios, previous PPH, grand multiparous
Interventions	10 IU of oxytocin administered IM versus 125 mcg of carboprost administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; blood loss (mL); third stage duration (minutes); diarrhoea; nausea; vomiting; headache; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	The blood loss during third stage of labour and the immediate postpartum period (1 hour after delivery) was estimated quantitatively using Brasss V Drape

Patil 2016 (*Continued*)

Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Penaranda 2002

Methods	3-arm active-controlled randomised trial
Participants	78 women were randomised in a hospital setting in Colombia. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with asthma, multiple pregnancy, intrauterine death, coagulopathy, cervical tear or water in the blood collector
Interventions	50 mcg of misoprostol administered sublingually versus 16 mIU/min of oxytocin administered by an IV versus 200 mcg of ergometrine administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; blood loss (mL; third stage duration (minutes); vomiting; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported

Penaranda 2002 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Investigators appraised blood loss from cord clamping until 1 hour after delivery
Incomplete outcome data (attrition bias) All outcomes	Low risk	3 women were excluded from the analysis after entering the study because of liquor contamination during blood collection
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Not all study participants were included in the analysis.
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Perez-Rumbos 2017

Methods	2-arm active-controlled randomised trial	
Participants	500 women were randomised in a hospital setting in Venezuela. The population comprised women of parity 4 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesareans, grand multiparous (>= 5), multiple pregnancy, previous caesareans, precipitate labour, anaemia (< 6 g/dL), chorioamnionitis, previous PPH, polyhydramnios, intrauterine fetal death, APH, asthma and hypersensitivity in any of the agents, clotting disorders, renal/liver disorders, epilepsy, hypertension, or those who did not consent to the study	
Interventions	600 mcg of misoprostol administered rectally versus 20 IU of oxytocin administered IM	
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; death; blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; nausea; vomiting; headache; fever; shivering	
Notes	Contact with study authors for additional information: no. Additional data from authors: no	
Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**

Perez-Rumbos 2017 (*Continued*)

Random sequence generation (selection bias)	Low risk	The numbers for the assignment to each treatment group were generated with a table of random numbers
Allocation concealment (selection bias)	Unclear risk	A sealed system was used that contained the location of each patient to the treatment groups. The envelopes were opened at the beginning of each treatment
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and care-givers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	The blood lost was collected in a calibrated and all the gauzes used were weighed
Incomplete outcome data (attrition bias) All outcomes	High risk	500 women were randomised in the study, but 108 were excluded because of missing data after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Poeschmann 1991

Methods	3-arm controlled randomised trial
Participants	77 women were randomised in a hospital setting in the Netherlands. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women if they had a Hobel Score of more than 10
Interventions	5 IU of oxytocin administered IM versus 500 mcg of sulprostone administered IM versus placebo
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; manual removal of placenta; blood loss (mL); third stage duration (minutes)

Poeschmann 1991 (*Continued*)

	; nausea
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Randomisation was within blocks of 10 but the sequence generation method was not reported
Allocation concealment (selection bias)	Low risk	Allocated identical numbered boxes containing trial medications
Blinding of participants and personnel (performance bias) All outcomes	Low risk	A nurse not involved with the delivery room prepared the injections
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinded.
Objective assessment of blood loss	Low risk	Blood loss was calculated by measuring the amount of blood and clots collected in the bedpan and by weighing the blood-stained swabs and linen obtained for 1 hour postpartum
Incomplete outcome data (attrition bias) All outcomes	Low risk	77 women were randomised in the study, but 3 were excluded because of induction of labour (n = 2) and instrumental delivery (n = 1) after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Sulprostone was supplied by Schering without charge but no other funding sources are reported

Prendiville 1988

Methods	2-arm controlled randomised trial
Participants	1695 women were randomised in a hospital setting in the UK. The population comprised women of both nulliparous and multiparous, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with cardiac disorder, antepartum haemorrhage, non-cephalic presentation, multiple

Prendiville 1988 (*Continued*)

	pregnancy, intrauterine death but after change in the protocol multiple other exclusion criteria were introduced
Interventions	500 mcg plus 5 IU of ergometrine plus oxytocin administered IM versus no treatment
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; change in Hb; NNU admissions; breastfeeding; vomiting; headache
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Low risk	Used sequentially-numbered, opaque, sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the South Western Regional Health Authority of the UK (public funding)

Quibel 2016

Methods	2-arm placebo-controlled randomised trial
Participants	1721 women were randomised in a hospital setting in France. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with multiple pregnancies, known hypersensitivity to prostaglandins, caesarean delivery, or participation in any other treatment trial
Interventions	400 mcg plus 10 IU of misoprostol plus oxytocin administered orally plus by an IV bolus versus 10 IU of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL;.change in Hb; diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	An independent, centralised, computer-generated randomisation sequence (CleanWeb; Télémedecine Technologies, Boulogne, France) was used for this allocation based on a randomisation list established by an independent statistician according to a permuted block method balanced and stratified by centre
Allocation concealment (selection bias)	Low risk	To conceal allocation, treatment boxes were sealed and numbered sequentially according to the randomisation sequence and were stored in the predelivery unit of each maternity ward
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The placebo tablets were provided by the pharmacy of the Assistance Publique-Hôpitaux de Paris. They were identical to misoprostol tablets in colour but their shape was slightly different. Therefore, the treatment was administered by a research midwife who did not otherwise participate in this trial, to maintain the treatment blind of patients and staff, before or after randomisation."

Quibel 2016 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Low risk	Quote: "The placebo tablets were provided by the pharmacy of the Assistance Publique-Hôpitaux de Paris. They were identical to misoprostol tablets in colour but their shape was slightly different. Therefore, the treatment was administered by a research midwife who did not otherwise participate in this trial, to maintain the treatment blind of patients and staff, before or after randomisation."
Objective assessment of blood loss	Low risk	Quote: "Blood loss was collected into a calibrated plastic bag placed under the mother's pelvis. The transparent, graduated bag allowed continuous monitoring of blood loss and was maintained in place for at least 2 hours after the neonate's delivery. It did not require sterilization and could be used in a dorsal, lateral, or lithotomy position. Blood from blood-soaked gauze swabs was also transferred into the plastic bag."
Incomplete outcome data (attrition bias) All outcomes	Low risk	1721 women were randomised in the study, but 118 were excluded because of caesarean during labour (n = 113) and withdrawals from the study (n = 5) after randomisation
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered prospectively (NCT01113229)
Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Low risk	Supported by a grant from Programme Hospitalier de Recherche Clinique Clinique-PHRC 2009 (Ministère de la Santé N° AOR 09010)

Rajaei 2014

Methods	2-arm active-controlled double-dummy randomised trial
Participants	400 women were randomised in a hospital setting in Iran. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with placenta praevia, placental abruption, coagulopathy, previous caesarean, macrosomia (more than

	4 kg), polyhydramnios or uncontrolled asthma
Interventions	20 IU of oxytocin administered by an IV infusion versus 400 mcg of misoprostol administered orally
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; blood loss (mL); change in Hb; hypotension; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Allocation using simple randomisation with computer-generated numbers in 1:1 ratio
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study was quote: "double-blind": "for blinding the study, identical-appearing solutions and tablets corresponding to the 2 pharmacological groups were prepared by the pharmacy and kept in the fridge until required"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss during the first hour after delivery, by collection with pads weighed before and after absorbance of blood
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	High risk	The study protocol was registered (ClinicalTrials.gov NCT01863706) but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of diarrhoea, nausea and vomiting were not completely reported) . Moreover, the study publication reports outcomes (hypotension, nausea, transfusion) not listed in the registered protocol

Rajaei 2014 (*Continued*)

Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the Hormozgan University of Medical Sciences (the institution of the authors)

Ramirez 2001

Methods	3-arm active-controlled randomised trial
Participants	An unspecified number of parturients were randomised in a hospital setting in Spain. The population comprised women of nulliparous, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised multiparous women, severe anaemia, hypertensive disorders
Interventions	5 IU of oxytocin administered by an IV bolus versus 200 mcg of ergometrine administered by an IV bolus versus no treatment
Outcomes	The study recorded the following outcomes: (No outcome data found)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.

Ramirez 2001 (*Continued*)

Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Rashid 2009

Methods	2-arm active-controlled randomised trial
Participants	686 women were randomised in a hospital setting in Saudi Arabia. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section or requiring oxytocin infusion in the third stage, or those with pre-eclampsia, cardiac disorder, hypertension on treatment, APH, pre-term labour (less than 37 weeks), postmaturity (more than 42 weeks) or Hb less or equal to 90 g/L
Interventions	500 mcg plus 5 IU of ergometrine plus oxytocin administered IM versus 10 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); third stage duration (minutes); nausea; vomiting; headache
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated random sequence of numbers.
Allocation concealment (selection bias)	Unclear risk	Used sequentially-numbered, sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations

Rashid 2009 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	High risk	Assessors were not blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss quote: "clinically in a standard way" by collection with a plastic sheet that was subsequently drained (with clots) into a graduated measuring jug, and by weighing swabs and towels. Quote "Any delayed haemorrhage within 24 hours after delivery was calculated"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Outcome data were collected completely from all randomised study participants
Selective reporting (reporting bias)	High risk	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of requirement for additional syntometrine [ergometrine plus oxytocin] were omitted)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Ray 2001

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing elective caesarean section, or those with pre-term labour (less than 32 weeks), prolonged labour, antepartum haemorrhage, pre-eclampsia, intrauterine death, multiple pregnancy, epilepsy, asthma, cardiac/kidney disorder, coagulopathy or anaemia
Interventions	400 mcg of misoprostol administered orally versus unspecified dose of ergometrine administered by an unspecified route
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; manual removal of placenta; hypertension

Ray 2001 (*Continued*)

Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Investigators appraised blood loss in the first 2 hours after delivery of the placenta, by "clinical estimation". However, blood loss data were not reported in a format that could be extracted for the purpose of this review
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	High risk	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Reddy 2001

Methods	3-arm active-controlled randomised trial
Participants	120 women were randomised in a hospital setting in India. The population comprised women of any parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with heart, liver or renal disease, asthma, epilepsy, Rhesus-negative, traumatic PPH, severe anaemia (< 6 g/dL) or hypertension
Interventions	200 mcg of ergometrine administered by an IV bolus versus 250 mcg of carboprost administered IM
Outcomes	The study recorded the following outcomes: blood loss (mL); third stage duration (minutes); diarrhoea; headache
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised

Reddy 2001 (*Continued*)

Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Reyes 2011

Methods	2-arm active-controlled randomised trial
Participants	144 women were randomised in a hospital setting in Panama. The population comprised women of parity 5 or more, a singleton pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing emergency caesarean section, or those with coagulopathy, unknown parity or known allergy to carbetocin
Interventions	100 mcg of carbetocin administered by an IV bolus versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; manual removal of placenta; breastfeeding; nausea; vomiting; headache; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	High risk	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were

Reyes 2011 (*Continued*)

		reported as results in the study report (cases of PPH were omitted)
Intention to treat analysis	High risk	Not all study participants were included in the analysis.
Funding source	Low risk	Ferring Pharmaceuticals donated carbetocin. No other external funding was required for the study

Reyes, Gonzalez 2011

Methods	2-arm active-controlled double-dummy randomised trial
Participants	57 women were randomised in a hospital setting in Panama. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both caesarean and vaginal delivery. Exclusion criteria comprised women with HELLP syndrome, blood dyscrasia or multiple pregnancy
Interventions	100 mcg of carbetocin administered by an IV bolus versus 10 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; change in Hb; third stage duration (minutes); breastfeeding; vomiting; headache; fever
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated code.
Allocation concealment (selection bias)	Low risk	Used opaque, sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study was quote "double-blind": "because the two drugs are administered differently, a double dummy system for administration was used"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.

Reyes, Gonzalez 2011 (*Continued*)

Incomplete outcome data (attrition bias) All outcomes	Low risk	2 women were excluded from the study analysis after randomisation (quote "1 given drug before expulsion of placenta; 1 ampoule of the drug broken before use")
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who withdrew from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Rogers 1998

Methods	2-arm controlled randomised trial
Participants	1512 women were randomised in a hospital setting in the UK. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing augmentation of labour or instrumental delivery or requiring epidural analgesia, or those with placenta praevia, previous PPH, antepartum haemorrhage, Hb less than 100 g/L or mean corpuscular volume less than 75 fL, non-cephalic presentation, multiple pregnancy, intrauterine death, grand multiparity (more than 5), fibroids, anticoagulation therapy, pre-term labour (less than 32 weeks) or contraindications to any of the drugs
Interventions	Unspecified of ergometrine plus oxytocin administered IM versus no treatment
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); third stage duration (minute); NNU admissions; breastfeeding; nausea; vomiting; headache; maternal satisfaction
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	The randomisation schedule used variably sized balanced blocks, and the randomisation envelopes were prepared in advance in the National Perinatal Epidemiology Unit (NEPU)

Rogers 1998 (*Continued*)

Allocation concealment (selection bias)	Low risk	Used sequentially-numbered, opaque, sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	High risk	Assessors were not blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending midwives
Incomplete outcome data (attrition bias) All outcomes	Low risk	Blood loss data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the Public Health and Operational Research Committee of the Anglia and Oxford Regional Health Authority, UK (public funding)

Rosseland 2013

Methods	3-arm placebo-controlled randomised trial
Participants	76 women were randomised in a hospital setting in Norway. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with pre-eclampsia, placenta praevia, placenta accreta, von Willebrand disease or other bleeding disorder or preoperative systolic arterial pressure less than 90 mmHg
Interventions	5 IU of oxytocin administered by an IV bolus versus 100 mcg of carbetocin administered by an IV bolus versus placebo
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; blood loss (mL); change in Hb; headache
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Rosseland 2013 (*Continued*)

Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	A computer-generated list of random numbers was used. The block size varied between 6 and 9. Stratified randomisation with 2 strata, BMI less than 30 and BMI of 30 or more
Allocation concealment (selection bias)	Low risk	Used sequentially-numbered, opaque, sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study was quote "double-blinded": "to maintain blinding of the participants and investigators, the test medicine was delivered to the Department of Anaesthesiology in 10 mL syringes containing 5 mL of solution marked only with trial identification and randomisation numbers. The 10-mL syringes with the test medicines were prepared by a staff anaesthesiologist, who was otherwise uninvolved in the study
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss with the following formula: (0.75 x height in inches x 50) + (weight in pounds x 50) x ((predelivery haematocrit measurement - postdelivery haematocrit measurement)/predelivery haematocrit measurement)
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered (ClinicalTrials.gov NCT00977769)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised

Funding source	High risk	The study was supported by funding from Ferring Pharmaceuticals

Sadiq 2011

Methods	2-arm active-controlled randomised trial
Participants	1865 women were randomised in a hospital setting in Nigeria. The population comprised women of parity 6 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing instrumental delivery, or those with diabetes, non-cephalic presentation, anaemia, APH, multiple pregnancy, grand multiparity (more than 6) or known allergy
Interventions	10 IU of oxytocin administered by an IV bolus versus 600 mcg of misoprostol administered orally
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; blood loss (mL); change in Hb
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Random assignments generated by dice-box.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Investigators appraised blood loss at delivery by collection with pre-calibrated kidney dishes
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote "46 of the administered questionnaires were invalidated leaving a total of 1819 valid questionnaires (912 for oxytocin and 907 for misoprostol)." The data were further reduced through a process of com-

Sadiq 2011 (*Continued*)

		puter randomisation so as to have equal study populations
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Not all study participants were included in the analysis.
Funding source	Low risk	The study was supported by funding from the University of Maiduguri Teaching Hospital. Study medications were donated by Emzor Pharmaceutical Industries

Samimi 2013

Methods	2-arm active-controlled double-blinded randomised trial
Participants	216 women were randomised in a hospital setting in Iran. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with hypertension, pre-eclampsia, uterine rupture, cervical tear, asthma, cardiovascular/renal/liver disorders, grand multiparity (not defined), fibroids or previous PPH
Interventions	100 mcg of carbetocin administered IM versus 200 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: severe maternal morbidity: intensive care admissions; additional uterotonics; death; change in Hb; nausea; vomiting; tachycardia; hypotension; shivering abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was performed using a random number table.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote "Patients and medical personnel were blinded to the type of drug"

Samimi 2013 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Blood loss was not measured.
Incomplete outcome data (attrition bias) All outcomes	Low risk	At 24 hours postpartum, blood samples could not be collected from 16 women (9 in the carbetocin group and 7 in the ergometrine plus oxytocin group)
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered (Iranian registry of clinical trials number 138810212854N2)
Intention to treat analysis	High risk	The authors excluded 16 study participants from the analysis because postpartum haemoglobin measurements were not available
Funding source	Unclear risk	The study was supported by funding from the Kashan University of Medical Sciences (the institution of the authors)

Shady 2017

Methods	3-arm active-controlled randomised trial
Participants	360 women were randomised in a hospital setting in Egypt. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with medical disorders as cardiac, hepatic, renal, neurologic disorders, thromboembolic disease, blood disorders, diabetes, gestational hypertension and pre-eclampsia, grand multiparous (> 5), multiple pregnancy, polyhydramnios, macrosomia, APH, prolonged and obstructed labour, scarred uterus or previous instrumental delivery and those suffering from hypersensitivity to tranexamic acid
Interventions	10 IU of oxytocin administered by an IV bolus versus 600 mcg of misoprostol administered sublingually
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; transfusion; diarrhoea; nausea; vomiting
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**

Shady 2017 (*Continued*)

Random sequence generation (selection bias)	Low risk	A statistician prepared computer-generated randomisation tables
Allocation concealment (selection bias)	Low risk	Investigators placed the allocation data in serially numbered closed opaque envelopes. Each envelope had a card noting the intervention type inside. The envelopes were opened only by the principal investigator administering the study medications according to the order of attendance of women
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Immediately after delivery of the baby, and after liquor drainage, the patient was placed over a blood drape of known weight and a graduated container was placed under the delivery bed to collect blood. The amount of blood collected in the blood drape was measured. Then the patient was given preweighed pads, which were weighed 4 hours postpartum
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Shrestha 2011

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in Nepal. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with polyhydramnios, chorioamnionitis, preterm labour, previous caesarean, asthma, cardiac disorder or contraindication/hypersensitivity to the use of prostaglandin and uterotonics
Interventions	1000 mcg of misoprostol administered rectally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; severe maternal morbidity: intensive care admissions; death; blood loss (mL); change in Hb; third stage duration (minutes); fever; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Randomly allocated as per the lottery technique.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss in the 48 hours postpartum, by collection with preweighed sterile pads and a calibrated bucket. All the soaked drapes and pads were weighed and the dry weights of these materials were subtracted to calculate blood loss on the basis that 1 g is equivalent to 1 mL
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Shrestha 2011 (*Continued*)

Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Singh 2009

Methods	4-arm active-controlled double-dummy randomised trial
Participants	300 women were randomised in a hospital setting in India. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing augmentation of labour, or those with intrauterine death, antepartum haemorrhage, multiple pregnancy, malpresentation, cardiac disorder, Rhesus-negative mother, hypertension, Hb less than 70 g/L or hypersensitivity/contraindication to prostaglandins
Interventions	400 or 600 mcg of misoprostol administered sublingually versus 5 IU of oxytocin administered by an IV bolus versus 200 mcg of ergometrine administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); third stage duration (minutes); fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	The drug packets were sealed and coded using a computer-generated random number chart by the same individual
Allocation concealment (selection bias)	Unclear risk	Used sealed drug packets.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study was quote "double-blind": active treatments and placebo treatments were "identical" and investigators were "thus blinded"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.

Singh 2009 (*Continued*)

Objective assessment of blood loss	Low risk	Investigators removed any linen soiled with amniotic fluid, and placed a disposable and absorbent pre-weighed linen saver sheet with a pre-weighed polythene bag under the mother to collect blood from the uterine cavity. Any blood clots were expressed from the vagina into the polythene bag, which was then removed and weighed. A fresh pre-weighed sanitary napkin was applied. Separate swabs were not included in the final calculation (addition of the various gravimetric measurements), that was performed 1 hour after delivery. Quote "The specific gravity of blood being 1.08, the amount of blood lost in mL was equal to the weight in grams"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (changes in Hb measurements were unspecified beyond textual summary that quote "all groups showed a slight decrease in mean haemoglobin concentration 24 hours postpartum [maximum decrease of 0.6 g/dL]; however, the difference was not significant [ANOVA, P > 0.05]")
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Sitaula 2017

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in Nepal. The population comprised women of parity 4 or less, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with polyhydramnios, uncontrolled diabetes mellitus, previous 2 or more caesarean deliveries, severe pre-

	eclampsia, multiple pregnancy, grand multipara, known coagulation disorder, caesarean delivery under GA, previous myomectomy, previous uterine rupture, abnormal placentation, sensitivity to misoprostol
Interventions	400 mcg plus 20 IU of misoprostol plus oxytocin administered rectally plus by an IV infusion versus 20 IU of oxytocin administered by an Quote infusion
Outcomes	The study recorded the following outcomes: PPH at 1000; transfusion; blood loss (mL) ; change in Hb
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer generated random table.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were objective involved weighing the swabs but also visual estimation quote "fist full of clot was 500 ml"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Soltan 2007

Methods	4-arm active-controlled randomised trial
Participants	1228 women were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with traumatic PPH, blood disorders, chorioamnionitis, placenta praevia or placental abruption
Interventions	200 mcg of ergometrine administered IM versus 600-1000 mcg of misoprostol administered sublingually
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was computer-generated.
Allocation concealment (selection bias)	Low risk	Used opaque, closed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	High risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by collection with a graduated plastic bag, and by weighing towels, linen and gauzes
Incomplete outcome data (attrition bias) All outcomes	High risk	Quote "144 women were excluded from analysis because they were exposed to trauma to the perineum, vagina or cervix during labour and had traumatic excessive bleeding"
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Soltan 2007 (*Continued*)

Intention to treat analysis	High risk	Not all study participants were included in the analysis.
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Sood 2012

Methods	2-arm placebo-controlled randomised trial
Participants	174 women were randomised in a hospital setting in India. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria were not specified
Interventions	400 mcg plus 20 IU of misoprostol plus oxytocin administered sublingually plus by an IV infusion versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; blood loss (mL); change in Hb; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was by computer-generated random numbers.
Allocation concealment (selection bias)	Low risk	Used sequentially-numbered, opaque, sealed envelopes made at pharmacy
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Study participants and caregivers were blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised intraoperative blood loss by collection with suction apparatus and sterile drapes before irrigation, and by evaluating the blood in abdominal swabs and gauzes

Sood 2012 (*Continued*)

Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Stanton 2013

Methods	2-arm cluster-controlled randomised trial
Participants	1586 women were randomised in a community setting in Ghana. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	10 IU of oxytocin administered IM versus no treatment
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; death
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	The 52 CHOs were randomly allocated equally to either the intervention or the control group; this allocation was stratified by both district and distance (#10 km or .10 km) to emergency obstetric care. The randomisation sequence was determined using Stata (version 12)
Allocation concealment (selection bias)	Low risk	Allocation concealment was not reported but less of an issue in cluster-randomised trials

Stanton 2013 (*Continued*)

Blinding of participants and personnel (performance bias) All outcomes	High risk	Quote "The random allocation was not masked".
Blinding of outcome assessment (detection bias) All outcomes	High risk	Assessors were not blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised postpartum blood loss by collection with a BRASS-V calibrated plastic drape placed under the mother, who was asked to remain recumbent for 1 hour following delivery of the baby, or for 2 hours if active bleeding persisted. Quote "Fluids, urine, and faeces were excluded from the blood loss measure by sweeping them to the side and into a receptacle"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote "7 and 9 enrolled women in the oxytocin and control arms, respectively, lacked a blood-loss measure"
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered (ClinicalTrials.gov NCT01108289)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the Bill and Melinda Gates Foundation (public funding)

Su 2009

Methods	2-arm active-controlled double-blinded randomised trial
Participants	370 women were randomised in a hospital setting in Singapore. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing elective caesarean section, or those with multiple pregnancy, previous PPH, coagulopathy, coronary artery disease, hypertension or hypersensitivity/contraindications for the use of syntometrine or carbetocin
Interventions	100 mcg of carbetocin administered IM versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM

Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); third stage duration (minutes); nausea; vomiting; headache; shivering; abdominal pain
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Randomisation was blocked and stratified by parity. The randomisation list with the allocation of the mode of intervention was forwarded from the Biostatistics Unit to the Department of Pharmacy at National University Hospital, where the purchased medications were kept
Allocation concealment (selection bias)	Low risk	Used opaque packages made at pharmacy.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote "The identities of the medications were not known to the midwives, obstetricians and the participants. The medication codes were only broken following completion of the trial"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the visual estimation of attending obstetricians and midwives
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Low risk	The study protocol was registered 2 years after beginning recruitment (ClinicalTrial.gov NCT00499005)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised

Funding source	Low risk	The study was supported by funding from the National Healthcare Group of Singapore (public funding)

Sultana 2007

Methods	2-arm active-controlled randomised trial
Participants	400 women were randomised in a hospital setting in Bangladesh. The population comprised women of both nulliparous and multiparous, unspecified whether singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with previous caesarean
Interventions	400 mcg of misoprostol administered orally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500. PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; shivering; abdominal pain
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians after collection in a plastic bowl
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Sultana 2007 (*Continued*)

Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Supe 2016

Methods	4-arm controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with medical disorders like pregnancy-induced hypertension, cardiac disease, sensitivity to prostaglandins, and history of previous caesarean section
Interventions	800 mcg of misoprostol administered rectally versus 200 mcg of ergometrine administered IM versus 125 mcg of carboprost administered IM versus no treatment
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes) ; diarrhoea; nausea; vomiting; fever; shivering; abdominal pain
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was carried out by using a randomisation table
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	The blood and blood clots in the kidney tray were weighed. A plastic pouch was placed under the buttocks prior to the delivery. The blood lost was col-

Supe 2016 (*Continued*)

		lected in this pouch. After the delivery of the placenta, the content of the pouch was transferred to a graduated jar
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	Funding was not required.

Surbek 1999

Methods	2-arm placebo-controlled randomised trial
Participants	65 women were randomised in a Hospital setting in Switzerland. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with multiple pregnancy, pre-eclampsia, previous PPH or antepartum haemorrhage
Interventions	600 mcg of misoprostol administered orally versus placebo
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; blood loss (mL); third stage duration (minute); NNU admissions; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Generated by random tables.
Allocation concealment (selection bias)	Low risk	Randomisation performed by pharmacy.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study was quote "double-masked": "for proper masking, the study drugs were prepared by the hospital pharmacy as three identical gelatine capsules"

Surbek 1999 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Taheripanah 2018

Methods	2-arm active-controlled randomised trial
Participants	220 women were randomised in a hospital setting in Iran. The population comprised women of nulliparous and multiparous, a singleton pregnancy, at high risk for PPH, who delivered by emergency caesarean section. Exclusion criteria comprised women refusing to co-operate, major therapeutic side effects, history of cardiac and renal diseases, pre-eclampsia, and twin pregnancy
Interventions	100 mcg of carbetocin administered by an IV bolus versus 30 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; blood loss (mL); change in Hb; nausea; vomiting; headache
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**

Taheripanah 2018 (*Continued*)

Random sequence generation (selection bias)	Unclear risk	Described as block randomisation.
Allocation concealment (selection bias)	Low risk	Selection and randomisation of the patients were performed by a coordinating nurse, using a series of sequentially numbered sealed envelopes; therefore, the sequence of allocation was hidden
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	The authors state Quote "The women and practitioners were not aware of the type of intervention" but blinding (of study participants and caregivers) was unclear as it is not described in sufficient detail
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of evaluating blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was registered retrospectively (NCT02079558)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Tewatia 2014

Methods	2-arm active-controlled randomised trial
Participants	100 women were randomised in a hospital setting in India. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with grand multiparity (more than 4), anaemia, malpresentation, polyhydramnios, antepartum haemorrhage, liver/renal disorder, previous caesarean, previous PPH, uterine anomaly, traumatic PPH or contraindications to use misoprostol or oxytocin

Interventions	10 IU of oxytocin administered by an IV infusion versus 600 mcg of misoprostol administered sublingually
Outcomes	The study recorded the following outcomes: PPH at 500. PPH at 1000; severe maternal morbidity: intensive care admissions; additional uterotonics; transfusion; death; blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated random number sequence.
Allocation concealment (selection bias)	Unclear risk	Used sequentially-numbered, opaque envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Quote "Due to [the] nature of administration of the drugs, [the] patient or clinical care team could not be blinded. However, [the] statistician was unaware of the group allocation"
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators removed any linen soiled with amniotic fluid, and placed a calibrated plastic bag under the mother to collect blood from the uterine cavity. After delivery of the placenta, a pre-weighed pad was placed high up in vagina until 1 hour afterwards. In cases of episiotomy, a separate pad was applied to the episiotomy site, and the fluid collected by this pad was not included in blood loss measurements
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Tewatia 2014 (*Continued*)

Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Thilaganathan 1993

Methods	2-arm controlled randomised trial
Participants	193 women were randomised in a hospital setting in UK. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing induction or augmentation of labour or instrumental delivery, or those with grand multiparity (not defined) , malpresentation, multiple pregnancy, previous caesarean, previous PPH, APH, hypertension in pregnancy, intrauterine death, PROM, cervical lacerations or third degree perineal tears
Interventions	No treatment versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); change in Hb; third stage duration (minutes)
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomly allocated using standard randomisation tables.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians

Thilaganathan 1993 (*Continued*)

Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was conducted without external funding.

Tripti 2006

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of nulliparous and multiparous, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with hypertension, cardiac disease, renal disease, gastrointestinal disorders, respiratory disease, endocrinal problems, coagulation disorder, and sensitivity to prostaglandin or methergin
Interventions	125 mcg of carboprost administered IM versus 200 mcg of ergometrine administered by an IV bolus
Outcomes	The study recorded the following outcomes: additional uterotonics; manual removal of placenta; blood loss (mL); third stage duration (minutes)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Randomisation was done using random number tables.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.

Tripti 2006 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Blood loss was estimated by blood and blood clots collected in the kidney tray and adding the difference in the weight of the drapes before use and after delivery
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Ugwu 2014

Methods	2-arm active-controlled randomised trial
Participants	120 women were randomised in a hospital setting in Nigeria. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women requiring general anaesthesia, or those with multiple pregnancy, placenta praevia, pre-eclampsia, eclampsia, undiagnosed vaginal bleeding, prolonged labour, prolonged obstructed labour, cardiac/renal/liver disorders or fever
Interventions	400 mcg plus 20 IU of misoprostol plus oxytocin administered sublingually plus by an IV infusion versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; severe maternal morbidity: intensive care admissions; additionaluterotonics; transfusion; death; blood loss (mL); fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**

Ugwu 2014 (*Continued*)

Random sequence generation (selection bias)	Low risk	Generated by random tables.
Allocation concealment (selection bias)	Low risk	Used sequentially-numbered, opaque envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Quote There were no look-alike placebo tablets for women who had oxytocin alone but the fact that no member of the obstetric team had knowledge of which agent the patient received, is expected to ensure allocation concealment. In addition, there was incomplete blinding of the anaesthetist, although this was not likely to affect the study outcome, since the anaesthetist's estimated blood loss was not used."
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Quote "There were no look-alike placebo tablets for women who had oxytocin alone but the fact that no member of the obstetric team had knowledge of which agent the patient received, is expected to ensure allocation concealment. In addition, there was incomplete blinding of the anaesthetist, although this was not likely to affect the study outcome, since the anaesthetist's estimated blood loss was not used."
Objective assessment of blood loss	Low risk	Investigators appraised intraoperative and postoperative blood loss by collection in a suction bottle. Furthermore, soiled drapes, abdominal packs and pieces of gauze were weighed and the known dry weights subtracted. Finally, vulva pads applied during the 4 hours post-operation, were also weighed and the known dry weights subtracted. Measurements obtained by these 3 methods were added together. Weight measurements were performed with a weighing scale made in China, of total weighing capacity of 5 kg and graduations of 0.25 g. Investigators considered that 1 g is equivalent to 1 mL of blood
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants

Ugwu 2014 (*Continued*)

Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of nausea, vomiting, diarrhoea, headaches, fatigue, dizziness, chills, flatulence and abdominal pain were omitted)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Un Nisa 2012

Methods	2-arm active-controlled randomised trial
Participants	100 women were randomised in a hospital setting in India. The population comprised women of parity 2 to 4, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with previous PPH, multiple pregnancy, previous caesarean, macrosomia, pre-eclampsia, diabetes, cardiac/lung/bleeding/clotting disorders or taking anticoagulants
Interventions	10 IU of oxytocin administered by an IV bolus versus 500 mcg plus 5 IU of ergometrine plus oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500.
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Study participants (patients) were divided by lottery system in the 2 groups, each group comprising of 50 patients
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations

Un Nisa 2012 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss after the delivery of baby quote "by squeezing the soaked pads and quantifying the amount of blood clots in a kidney tray of standard size to be equal to 500 mL"
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Uncu 2015

Methods	5-arm controlled randomised trial
Participants	248 women were randomised in a hospital setting in Turkey. The population comprised women of parity 5 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with placenta praevia, previous PPH, APH, non-cephalic presentation, multiple pregnancy, intrauterine death, grand multiparity (more than 5), fibroids, pre-eclampsia or anticoagulation therapy
Interventions	No treatment versus 400 mcg to 800 mcg of misoprostol administered orally, vaginally or rectally
Outcomes	The study recorded the following outcomes: additional uterotonics; transfusion; third stage duration (minutes); diarrhoea; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**

Uncu 2015 (*Continued*)

Random sequence generation (selection bias)	Low risk	Generated by random tables.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Vagge 2014

Methods	2-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with cardiac disorder in pregnancy, uterine tumour in pregnancy, secondary PPH, grand multiparity (not defined), multiple pregnancy, polyhydramnios, anaemia, coagulopathy, antepartum haemorrhage, previous PPH, prolonged labour, precipitate labour or known allergic or hypersensitivity reaction to prostaglandins
Interventions	10 IU of oxytocin administered by an IV infusion versus 800 mcg of misoprostol administered rectally
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; blood loss (mL); diarrhoea; nausea; fever; shivering

Vagge 2014 (*Continued*)

Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Used simple random sampling.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Unclear risk	Methods of appraising blood loss were not reported.
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Vaid 2009

Methods	3-arm active-controlled randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with grand multiparity (more than 4), multiple pregnancy, preterm labour (less than 32 weeks), HELLP syndrome, polyhydramnios, coagulopathy, asthma, cardiac/renal disorder, epilepsy, hypertension, Hb less than 80 g/L or known drug allergy

Vaid 2009 (*Continued*)

Interventions	400 mcg of misoprostol administered sublingually versus 200 mcg of ergometrine administered IM versus 125 mcg of carboprost administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; transfusion; manual removal of placenta; diarrhoea; nausea; vomiting; fever; shivering; abdominal pain
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Allocation by a computer-generated random number.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was unclear.
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	After the drainage of amniotic fluid, investigators appraised blood loss by collection with a sterile calibrated BRASS-V drape placed under the mother. The drape remained in placed for 1 hour. Furthermore, quote "blood loss in gauze pieces was calculated by subtracting the weight of dry gauze from the weight of blood-soaked gauze pieces"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised

Vaid 2009 (*Continued*)

Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Van Selm 1995

Methods	2-arm active-controlled double-dummy randomised trial
Participants	81 women were randomised in a hospital setting in the Netherlands. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with coagulation disorder, anticoagulant medication, multiple pregnancy, fibroids, hypertension, induction of labour
Interventions	200 mcg plus 5 IU of ergometrine plus oxytocin administered IM versus 500 mcg of sulprostone administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; transfusion;manual removal of placenta; blood loss (mL); third stage duration (minutes)
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Low risk	Assignment to pharmacy coded boxes occurred, after informed consent, in first stage labour
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Double-blinding of personnel and participants (placebo use).
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Double-blinding of personnel and participants (placebo use).
Objective assessment of blood loss	Low risk	Measured the blood and clots by collecting and weighing the blood stained linen and pads
Incomplete outcome data (attrition bias) All outcomes	High risk	81 women were randomised in the study, but 12 were excluded because of exclusion criteria all in the ergometrine plus oxytocin

Van Selm 1995 (*Continued*)

		group after randomisation
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Verma 2006

Methods	2-arm active-controlled double-dummy randomised trial
Participants	200 women were randomised in a hospital setting in India. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified
Interventions	400 mcg of misoprostol administered sublingually versus 200 mcg of ergometrine administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; additional uterotonics; manual removal of placenta; blood loss (mL); change in Hb; third stage duration (minutes); nausea; fever; Shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Sequence generation was not reported.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The study was "double-blind": active treatments and placebo treatments were "identical-looking"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.

Verma 2006 (*Continued*)

Objective assessment of blood loss	Low risk	Investigators appraised blood loss quote: "accurately with a specially designed calibrated blood collection drape (BRASS-V drape)"
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	It was unclear from the study report whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were unclear.

Vimala 2004

Methods	2-arm active-controlled randomised trial
Participants	120 women were randomised in a hospital setting in India. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing induction or augmentation of labour or caesarean section, or those with preterm labour (less than 37 weeks) , grand multiparity (more than 5), multiple pregnancy, hypertension in pregnancy, Hb less than 80 g/L or known hypersensitivity to prostaglandins
Interventions	400 mcg of misoprostol administered sublingually versus 200 mcg of ergometrine administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; blood loss (mL); change in Hb; third stage duration (minutes); nausea; vomiting; headache; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Generated by random tables.

Allocation concealment (selection bias)	Low risk	Used sequentially-numbered, opaque, sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Treatments were administered via different routes and the authors did not report any double dummy
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss by the estimation of attending nurses and obstetricians. After delivery of the baby, amniotic fluid was allowed to drain away, and amniotic fluid-soaked bed linens were covered with dry disposable 'linen-savers'. A wedge-shaped plastic bedpan was placed under the mother for 1 hour. Blood and clots from the bedpan were decanted into a measuring cylinder and measured. Blood-soaked swabs and linen-savers were weighed; the known dry weights were subtracted, for the weight of blood contained within them to be added to the value indicated by the measuring cylinder
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Vimala 2006

Methods	2-arm active-controlled randomised trial
Participants	100 women were randomised in a hospital setting in India. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women with multiple pregnancy, APH, polyhydramnios, prolonged labour (more than 12 hours), previous more than 1 caesarean, previous uterine rupture, cardiac/liver/renal disorder, coagulopathy or Hb less than 80 g/L
Interventions	400 mcg of misoprostol administered sublingually versus 20 IU of oxytocin administered by an IV infusion
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; blood loss (mL); change in Hb; vomiting; headache; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated random number.
Allocation concealment (selection bias)	Low risk	Used opaque, sealed envelopes.
Blinding of participants and personnel (performance bias) All outcomes	High risk	Study participants and caregivers were not blinded to treatment allocations
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.
Objective assessment of blood loss	Low risk	Investigators appraised blood loss intraoperatively and in the first hour postoperatively "in a standard manner". They measured the volume of blood in the suction bottle, and weighed blood-soaked sponges and linen savers. Then they added the difference between dry and blood-soaked weights of sponges and linen savers, to the volume measured in the suction bottle
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.

Vimala 2006 (*Continued*)

Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from the Division of Reproductive Health and Nutrition, Indian Council of Medical Research (public funding)

Walley 2000

Methods	2-arm active-controlled double-dummy randomised trial
Participants	401 women were randomised in a hospital setting in Ghana. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing induction or augmentation of labour or caesarean section, or those with grand multiparity (more than 5) , multiple pregnancy, preterm labour (less than 32 weeks), hypertension in pregnancy, HELLP syndrome, polyhydramnios, previous PPH, coagulopathy, precipitate labour, chorioamnionitis, Hb less than 80 g/L or a known hypersensitivity to prostaglandins
Interventions	400 mcg of misoprostol administered orally versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes); diarrhoea; nausea; vomiting; fever; shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Computer-generated random numbers.
Allocation concealment (selection bias)	Low risk	Used sequentially-numbered, opaque packets made by administrative staff
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "The identity of the placebo and active medications were concealed from caregivers and participants"

Walley 2000 (*Continued*)

Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	High risk	Investigators appraised blood loss by the estimation of attending physicians
Incomplete outcome data (attrition bias) All outcomes	Low risk	Of those women randomised, blood loss measurements were unavailable in 3 cases, and postpartum Hb samples were unavailable in 9 cases
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The study was supported by funding from MaterCare International and the Canadian International Development Agency (public funding)

Whigham 2016

Methods	2-arm active-controlled double-blinded randomised trial
Participants	122 women were randomised in a hospital setting in Australia. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by emergency caesarean section. Exclusion criteria comprised women undergoing elective caesarean section or requiring general anaesthesia, or those with vascular/liver/renal disorders, preterm labour (less than 37 weeks), multiple pregnancy, placenta praevia, placental abruption, previous more than 2 caesareans or an adverse reaction to carbetocin/oxytocin
Interventions	100 mcg of carbetocin administered by an IV bolus versus 5 IU of oxytocin administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 1000; additional uterotonics; transfusion; blood loss (mL); change in Hb
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes
Risk of bias	

Whigham 2016 (*Continued*)

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Computer-generated randomisation at pharmacy level and none of the operating or anaesthetic doctors will have access to this
Allocation concealment (selection bias)	Low risk	Randomisation performed by pharmacy.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Pharmacy used a study label, which included study title, number and expiry date to cover the trade label. Patients, anaesthetists and operating obstetricians were blinded to the intervention drug. These ampoules were stocked in the emergency theatre fridge in boxes labelled only with the matching study label
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Low risk	Investigators appraised intra-operative blood loss by the estimation of attending physicians. Excess blood was collected in measuring container by suction, and weighed together with any swabs soaked in blood
Incomplete outcome data (attrition bias) All outcomes	Low risk	114 women were randomised in the study, but 10 were excluded because they had a general anaesthetic (n = 2) or ampoules discarded (n = 8) after randomisation
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered prospectively (ACTRN 12612000466842)
Intention to treat analysis	High risk	Those who were excluded from the study after randomisation were not included in the analysis
Funding source	Low risk	This project was awarded the Peninsula Health Grant for Health Research

Widmer 2018

Methods	2-arm active-controlled double-blinded randomised trial
Participants	29645 women were randomised in a hospital setting in Argentina, Egypt, India, Kenya, Nigeria, Singapore, South Africa, Thailand, Uganda and the UK. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women in an advanced stage of labour (cervical dilatation > 6 cm) or who were too distressed to give informed consent, who had known allergies to carbetocin, oxytocin homologues or excipients, who had serious cardiovascular disorders, serious hepatic or renal disease, or who had epilepsy
Interventions	100 mcg of carbetocin administered IM versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; severe maternal morbidity: intensive care admissions; additional uterotonics; transfusion; manual removal of placenta; death; vomiting; abdominal pain
Notes	Contact with study authors for additional information: no. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	The random allocation sequence was generated at WHO using computer-generated random numbers. Randomisation was stratified by country using permuted blocks of size ten, with an allocation ratio 1:1
Allocation concealment (selection bias)	Low risk	Both HS carbetocin and oxytocin were in 1 mL ampoules in consecutively numbered treatment packs arranged in dispensers. Allocation was by opening the consecutively numbered treatment pack in the dispenser
Blinding of participants and personnel (performance bias) All outcomes	Low risk	The ampoules, trial packs and dispensers were identical in shape, size and weight ensuring that investigators were blinded to individual treatment allocation. Although carbetocin was heat stable and did not require cold storage we kept the dispensers in cold storage (2° C to 8° C) to give oxytocin maximum efficacy and maintain double-blinding
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinded.

Objective assessment of blood loss	Low risk	Once the cord was clamped and cut, a blood collection plastic drape (BRASSS-V™) was placed under the woman's buttocks. The blood was collected for 1 hour, or 2 hours if the bleeding continued beyond 1 hour. The drape with the blood was then weighed by a digital scale, the weight recorded in grams and then converted to volume (mL) at the analysis stage
Incomplete outcome data (attrition bias) All outcomes	Low risk	Data were collected completely from all randomised study participants
Selective reporting (reporting bias)	Low risk	The study report matches the study protocol that was registered prospectively (Trial registration: HRP Trial A65870; UTN U1111-1162-8519; ACTRN12614000870651; CTRI/2016/05/006969, EUDRACT 2014-004445-26)
Intention to treat analysis	Low risk	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Low risk	The research in this publication was supported by funding from MSD, through its MSD for Mothers Program. MSD for Mothers is an initiative of Merck & Co., Inc., Kenilworth, N.J., USA.. The funder had no commercial interest in the investigational drug, no influence on the protocol, the statistical analysis plan and the final manuscript; the funder could provide comments, but there was no obligation on the trial team to accept any. The HS carbetocin was provided by Ferring International Center S.A. (Saint Prex, Switzerland) and oxytocin by Novartis (Basel, Switzerland) free of charge. Neither company had any influence on any of the trial documents or processes

Yuen 1995

Methods	2-arm active-controlled double-blinded randomised trial
Participants	1000 women were randomised in a hospital setting in Hong Kong. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women requiring oxytocin infusion in the third stage, or those with pre-eclampsia or cardiac disorder
Interventions	500 mcg plus 5 IU of ergometrine plus oxytocin administered IM versus 10 IU of oxytocin administered IM
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; severe maternal morbidity: intensive care admissions; additional uterotonics; transfusion; manual removal of placenta; death; change in Hb; nausea; vomiting; headache
Notes	Contact with study authors for additional information: yes. Additional data from authors: no

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Used computer-generated random numbers.
Allocation concealment (selection bias)	Unclear risk	Used sequentially-numbered, opaque envelopes.
Blinding of participants and personnel (performance bias) All outcomes	Low risk	Quote: "When a patient entered the study, a nursing officer who was not involved in the management of the patient drew up the indicated medication and handed this to the patient's attendants". Study participants and caregivers were thus blinded to treatment allocations until the codes were revealed after all data were collected in the study
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessors were blinded to treatment allocations.
Objective assessment of blood loss	Unclear risk	Investigators appraised blood loss during delivery quote: "by measuring the amount of blood clots and weighing the towels used"
Incomplete outcome data (attrition bias) All outcomes	Low risk	Quote: "9 [randomised participants] were excluded: 3 had a twin pregnancy, 1 had blood transfusion during labour, and the

Yuen 1995 (*Continued*)

		other 5 had unavailable records"
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	High risk	Not all study participants were included in the analysis.
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

Zachariah 2006

Methods	3-arm active-controlled randomised trial
Participants	2023 women were randomised in a hospital setting in India. The population comprised women of both nulliparous and multiparous, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesarean section, or those with asthma, cardiac disorder, rhesus factor incompatibility or hypertension
Interventions	400 mcg of misoprostol administered orally versus 10 IU of oxytocin administered IM versus 200 mcg of ergometrine administered by an IV bolus
Outcomes	The study recorded the following outcomes: PPH at 500; PPH at 1000; additional uterotonics; transfusion; manual removal of placenta; death; blood loss (mL); change in Hb; third stage duration (minutes). Diarrhea. Nausea. Vomiting. Headache. Fever. Shivering
Notes	Contact with study authors for additional information: yes. Additional data from authors: yes

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	Used computer-generated random numbers.
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not reported.
Blinding of participants and personnel (performance bias) All outcomes	Unclear risk	Blinding (of study participants and caregivers) was not reported
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Assessor blinding was not reported.

Objective assessment of blood loss	Low risk	After the drainage of amniotic fluid, investigators appraised blood loss by collection with a large sterile plastic bag placed under the mother until she was transferred to the postnatal department. The blood collected in the plastic bag was then transferred to a measuring jar. Mops were not used in the labour room, and gauze pieces were counted
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	The study authors did not mention any incomplete outcome data
Selective reporting (reporting bias)	Unclear risk	The protocol of the study was unavailable for verification.
Intention to treat analysis	Unclear risk	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised
Funding source	Unclear risk	Source(s) of funding for the study were not reported.

ACTRN: Australian Clinical Trials Registration Number; **ANOVA:** one-way Analysis of variance; **APH:** antepartum haemorrhage; **ASA I or II:** ASA Physical Status Classification System: ASA I represents a normal healthy patient, ASA II represents a patient with mild systemic disease; **BMI:** Body Mass Index; **cc:** cubic centimetres; **CHOs:** community health officers; **cm:** centimetres; **CS**: caesarean section; **CTRI:** Clinical Trials Registry of India; **DIC:** disseminated intravascular coagulopathy; **dL:** decilitres; **EudraCT:** European Clinical Trials database; **fL:** femtolitres (measurement of mean corpuscular volume); **g:** gram; **Hb:** haemoglobin; **HELLP syndrome:** Hemolysis (destruction of red blood cells), Elevated Liver enzymes (which indicate liver damage), and Low Platelet count; **HIV:** human Immunodeficiency virus; **Hong Kong SAR:** Hong Kong Special Adminstrative Region; **IM:** intramuscularly; **IU:** International Units; **IV:** intravenous; **kg:** kilograms; **km:** kilometres; **L**, litres; **mcg:** micrograms; **MCV:** mean cell volume; **mg:** milligrams; **mgSO4:** magnesium sulphate; **min:** minutes; **mL:** millilitres; **mmHG:** millimetres of mercury (unit of pressure); **mmol:** millimoles; **NCT:** National Clinical Trial (number); **NEPU:** National Perinatal Epidemiology Unit; **NHS:** National Health Service; **nm:** nanometres; **NNU:** Neonatal Unit; **PACTR:** Pan African Clinical Trials Registry; **PCV:** packed cell volume; **PPH:** postpartum haemorrhage; **PROM:** premature rupture of membranes; **RCOG:** Royal College of Obstetricians and Gynaecologists; **UK:** United Kingdom; **UNDP/UNFPA:** United Nations Development Programme/United Nations Population Fund; **USA:** United States of America; **WHO:** World Health Organization.

Characteristics of excluded studies *[ordered by study ID]*

Study	Reason for exclusion
Abdel-Aleem 2013	Not eligible intervention
Abdel-Aleem 2018	Same drug intervention both arms and only different timing of oxytocin administration
Abdollahy 2000	Not eligible intervention
Adhikari 2007	Quasi-randomised
Adnan 2017	Same drug intervention both arms only different route of oxytocin administration
Ahmed 2015	Not eligible intervention
Akinaga 2016	Not eligible intervention
Al-Harazi 2009	Same drug intervention both arms and only different route of misoprostol administration
Alam 2017	Not randomised
Ali 2012	Quasi-randomised
Ali 2018	Not randomised
Anandakrishnan 2013	Same drug intervention both arms and only different dose of carbetocin administration
Anjaneyulu 1988	Not eligible intervention
Anvaripour 2013	Intervention given after the third stage of labour
Ashwal 2016	Same drug intervention both arms only different regimen of oxytocin administration
Athavale 1991	Not eligible intervention
Ayedi 2011	Same drug intervention both arms and only different dose of oxytocin administration
Ayedi 2011b	Not eligible intervention
Ayedi 2012	Not eligible intervention
Aziz 2014	Quasi-randomised
Bader 2000	Not eligible intervention
Badhwar 1991	Not eligible intervention

(*Continued*)

Bai 2014	Not eligible intervention
Baig 2015	Not eligible intervention
Balki 2006	Same drug intervention both arms and only different dose of oxytocin administration
Banovska 2013	Not eligible intervention
Barbaro 1961	Not eligible intervention
Baumgarten 1983	Intervention given after the third stage of labour
Bhattacharya 1988	Not eligible intervention
Bhavana 2013	Not eligible intervention
Bider 1991	Not eligible intervention
Bider 1992	Not eligible intervention
Bisri 2011	Same drug intervention both arms and only different regimen of oxytocin administration
Bivins 1993	Not eligible intervention
Blum 2010	Intervention for treatment of PPH
Bonham 1963	Quasi-randomised
Bonis 2012	Quasi-randomised
Boopathi 2014	Quasi-randomised
Bose 2017	Not eligible intervention
Bulusu 2017	Same drug intervention both arms only different route of misoprostol administration
Cappiello 2006	Not eligible intervention
Carvalho 2004	Same drug intervention both arms and only different dose of oxytocin administration
Catanzarite 1990	Not eligible intervention
Chaplin 2009	Same drug intervention both arms and only different dose of oxytocin administration
Chatterjee 2016	Intervention given after the third stage of labour

(*Continued*)

Chaudhuri 2014	Intervention given after the third stage of labour
Chestnut 1987	Not eligible intervention
Chou 1994	Not eligible intervention
Chou 2015	Same drug intervention both arms only different dose of oxytocin administration
Chukudebelu 1963	Quasi-randomised
Cooper 2004	Same drug intervention both arms and only different regimen of oxytocin administration
Cordovani 2011	Same drug intervention all arms only different dose of carbetocin administration
Cordovani 2012	Same drug intervention both arms and only different dose of carbetocin administration
Dagdeviren 2016	Same drug intervention both arms only different route of oxytocin administration
Dahiya 1995	Not eligible intervention
Daley 1951	Quasi-randomised
Daly 1999	Inappropriate population
Dao 2009	Intervention for treatment of PPH
Davies 2005	Same drug intervention both arms and only different regimen of oxytocin administration
De bonis 2012	Quasi-randomised
Dell-Kuster 2017	Same drug intervention both arms only different infusion rate of carbetocin administration
Dennehy 1998	Not eligible intervention
Deshpande 2016	Not eligible intervention
Diab 1999	Quasi-randomised
Dickinson 2009	Not eligible population (terminations 2nd trimester)
Diop 2011	Study withdrawn
Dommisse 1980	Not randomised
Dong 2011	Not eligible intervention
Dumoulin 1981	Not randomised

(*Continued*)

Durocher 2012	Not randomised
Dutta 2000	Quasi-randomised
Dweck 2000	Not eligible intervention
Dzuba 2012	Same drug intervention both arms and only different route of oxytocin administration
Elati 2011	Same drug intervention both arms and only different dose of misoprostol administration
Erkkola 1984	Not eligible intervention
Farber 2013	Not eligible intervention
Farber 2015	Not eligible intervention
Fatemeh 2011	Same drug intervention both arms and only different regimen of oxytocin administration
Forster 1957	Quasi-randomised
Francis 1965	Quasi-randomised
Friedman 1957	Quasi-randomised
Fugo 1958	Quasi-randomised
Gai 2004	Not eligible intervention
Gavhane 2017	Not randomised
George 2010	Same drug intervention both arms and only different dose of oxytocin administration
Ghulmiyyah 2007	Not eligible intervention
Ghulmiyyah 2017	Same drug intervention all arms only different dose of oxytocin administration
Gobbur 2011	Not eligible intervention
Gohel 2007	Not eligible intervention
Goswami 2013	Not eligible intervention
Groeber 1960	Quasi-randomised
Gungorduk 2010	Not eligible intervention
Gungorduk 2010b	Same drug intervention both arms and only different regimen of oxytocin administration

(*Continued*)

Gungorduk 2011	Not eligible intervention
Gungorduk 2013	Not eligible intervention
Gupta 2014	Not eligible intervention
Habek 2007	Not eligible intervention
Hacker 1979	Not randomised
Halder 2013	Not eligible intervention
Hoffman 2006	Same drug intervention both arms and only different timing of oxytocin administration
Hofmeyr 2004	Intervention for treating PPH
Howard 1964	Not eligible intervention
Huh 2004	Same drug intervention both arms and only different timing of oxytocin administration
Hunt 2013	Not eligible intervention
Häivä 1994	Quasi-randomised
Ilancheran 1990	Not randomised
Irons 1994	Inappropriate population (excluded women who had PPH)
Islam 2008	Not randomised
Jackson 2001	Same drug intervention both arms and only different timing of oxytocin administration
Jagielska 2015	Not randomised
Javadi 2015	Not eligible intervention
Jiang 2001	Same drug intervention both arms and only different dose of oxytocin administration
Jin 2000	Not eligible intervention
Jolivet 1978	Not eligible intervention
Jonsson 2010	Same drug intervention both arms and only different dose of oxytocin administration
Kashanian 2010	Intervention administered after the third stage of labour
Kemp 1963	Quasi-randomised

(*Continued*)

Khan 1997	Not eligible intervention
Khan 2003	Same drug intervention both arms and only different route of misoprostol administration
Khan 2012	Same drug intervention both arms and only different regimen of oxytocin administration
Khan 2013	Same drug intervention all arms only different dose of carbetocin administration
Khanun 2011	Same drug intervention both arms and only different route of misoprostol administration
Kikutani 2003a	Innapropriate population
Kikutani 2003b	Innapropriate population
Kikutani 2006	Not randomised
King 2010	Same drug intervention both arms and only different regimen of oxytocin administration
Kintu 2012	Same drug intervention both arms and only different dose of oxytocin administration
Kiran 2012	Same drug intervention both arms and only different dose of oxytocin administration
Kore 2000	Not eligible intervention
Kovacheva 2015	Same drug intervention both arms and only different regimen of oxytocin administration
Kovavisarach 1998	Not eligible intervention
Le 2000	Not randomised
Leader 2002	Not eligible population (2nd trimester)
Li 2002	Not eligible intervention
Li 2003	Not eligible intervention
Li 2011	Not eligible intervention
Lin 2009	Not eligible intervention
Liu 1997	Not eligible intervention
Liu 2002	Not eligible intervention
Liu 2015	Not eligible intervention
Liu 2016	Not eligible intervention

(*Continued*)

Luamprapas 1994	Not eligible intervention
Maged 2015	Not eligible intervention
Makvandi 2013	Not eligible intervention
Mangla 2012	Not eligible intervention
Mankuta 2006	Not eligible intervention
Mansouri 2011	Same drug intervention both arms and only different route of misoprostol administration
Martinez 2006	Not eligible intervention
McGinty 1956	Quasi-randomised
Miller 2009	Not eligible intervention
Mirghafourvand 2015	Not eligible intervention
Mirteimouri 2013	Not randomised
Mockler 2015	Same drug intervention both arms only different route of oxytocin administration
Mohamadian 2013	Same drug intervention both arms only different timing of oxytocin administration
Mollitt 2009	Same drug intervention both arms and only different regimen of oxytocin administration
Moore 1956	Same drug intervention both arms and only different type of the same drug
Movafegh 2011	Not eligible intervention
Munishankarappa 2009	Same drug intervention both arms and only different regimen of oxytocin administration
Munn 2001	Same drug intervention both arms and only different regimen of oxytocin administration
Murphy 2009	Same drug intervention both arms and only different regimen of oxytocin administration
Murphy 2015	Same drug intervention both arms only different route of oxytocin administration
Nankali 2013	Not eligible intervention
Narenji 2012	Not randomised
Nelson 1983	Not eligible intervention

(*Continued*)

Neri-Mejia 2016	Same drug intervention all arms only different route and regimen of oxytocin administration
Newton 1961	Quasi-randomised
Nguyen-Lu 2015	Same drug intervention all arms only different dose of carbetocin administration
Nieminen 1964	Not randomised
Oberbaum 2005	Not eligible intervention
Oguz 2014	Same drug intervention both arms and only different route and timing of oxytocin administration
Ononge 2015	Self-administration of uterotonic agent
Ozalp 2010	Not eligible intervention
Ozcan 1996	Not eligible intervention
Ozkaya 2005	Inappropriate population (excluded women who had PPH)
Padhy 2006	Not eligible intervention
Palacio 2011	Same drug intervention both arms and only different dose of oxytocin administration
Paull 1977	Same drug intervention both arms and only different doses of drug administration
Pei 1996	Not randomised
Perdiou 2009	Not eligible intervention
Phromboot 2010	Not eligible intervention
Pierre 1992	Quasi-randomised
Pinder 2002	Same drug intervention both arms and only different doses of drug administration
Pisani 2012	Quasi-randomised
Porter 1991	Not eligible intervention
Priya 2015	Inappropriate population (measured blood loss after the delivery of the placenta)
Puri 2012	Not eligible intervention
Qiu 1999	Not eligible population (second stage of labour)
Quiroga 2009	Not eligible intervention

(*Continued*)

Ragab 2016	Same drug intervention both arms only different timing of misoprostol administration
Raghavan 2016	Intervention given for treatment of PPH
Rahbar 2018	Quasi-randomised
Rajwani 2000	Not eligible intervention
Ray 2012	Same drug intervention both arms only different regimen of oxytocin administration
Razali 2016	Quasi-randomised
Reddy 1989	Not eligible intervention
Rezk 2018	Same drug intervention both arms only different route of misoprostol administration
Rooney 1985	Quasi-randomised
Rosales-Ortiz 2014	Quasi-randomised
Rouse 2011	Same drug intervention both arms and only different doses of drug administration
Sadeghipour 2013	Not eligible intervention
Saito 2007	Quasi-randomised
Sallam 2018	Intervention administered for treatment of PPH
Samuels 2005	Not eligible intervention
Sangkhomkhamhang 2012	Same drug intervention both arms only different route of oxytocin administration
Sariganont 1999	Not randomised
Sarna 1997	Same drug intervention both arms and only different doses of drug administration
Sartain 2008	Same drug intervention both arms and only different doses of drug administration
Savitha 2017	Quasi-randomised
Schaefer 2004	Same drug intervention both arms and only different timings of drug administration
Schemmer 2001	Same drug intervention both arms and only different timings of drug administration
Sekhavat 2009	Not eligible intervention
Sentilhes 2015	Not eligible intervention

(*Continued*)

Senturk 2013	Not eligible intervention
Senturk 2016	Not randomised
Shahid 2013	Not eligible intervention
Sharma 2014	Not randomised
Sheehan 2011	Same drug intervention both arms and only different doses of drug administration
Shirazi 2013	Not eligible intervention
Shrestha 2007	Not eligible intervention
Shrestha 2008	Not eligible intervention
Singh 2005	Quasi-randomised
Siriwarakul 1991	Not eligible intervention
Soiva 1964	Not randomised
Soleimani 2014	Quasi-randomised
Sorbe 1978	Quasi-randomised
Soriano 1995	Quasi-randomised
Sreelatha 2017	Same drug intervention all arms only different route of misoprostol administration
Stearn 1963	Not randomised
Svanstrom 2008	Innapropriate population
Swapnika 2018	Not randomised
Symes 1984	Inapropriate population
Taj 2014	Not eligible intervention
Takagi 1976	Not eligible intervention
Tali 2016	Not eligible intervention
Tanir 2009	Not eligible intervention
Tarabrin 2012	Not eligible intervention

(*Continued*)

Tariq 2015b	Administered for treatment of PPH
Tehseen 2008	Not eligible intervention
Terry 1970	Not eligible intervention
Tessier 2000	Same drug intervention both arms and only different regimen of drug administration
Tharakan 2008	Same drug intervention both arms and only different timings of drug administration
Thomas 2007	Same drug intervention both arms and only different regimen of drug administration
Thornton 1988	Quasi-randomised
Tita 2012	Same drug intervention both arms and only different doses of drug administration
Tripti 2009	Not randomised
Tudor 2006	Not eligible intervention
Ugwu 2016	Same drug intervention both arms and only different doses of drug administration
Van den Enden 2009	Same drug intervention both arms and only different regimen of drug administration
Vasegh 2005	Quasi-randomised
Vaughan Williams 1974	Innapropriate population
Ventoskovskiy 1990	Not eligible intervention
Vogel 2004	Not eligible outcomes
Wallace 2007	Same drug intervention both arms and only different regimen of oxytocin administration
Walraven 2005	Not eligible uterotonic (oral ergometrine)
Wang 2000	Not eligible intervention
Wang 2018	Not randomised
Weeks 2015	Self-administration of uterotonic agent
Weihong 1998	Same drug intervention both arms and only different routes of drug administration
Weiss 1975	Not eligible outcomes

(*Continued*)

Wellmann 2016	Intervention administered before the third stage of labour
Wetta 2013	Same drug intervention both arms and only different doses of drug administration
Winikoff 2012	Same drug intervention both arms and only different routes of drug administration
Winikoff 2016	Same drug intervention all arms only different route of oxytocin administration
Wong 2005a	Same drug intervention both arms and only different doses of drug administration
Wong 2005b	Study withdrawn
Wright 2005	Not eligible intervention
Wu 2007	Not eligible intervention
Xu 2003	Not eligible intervention
Xu 2013	Not eligible intervention
Yamaguchi 2011	Same drug intervention both arms and only different regimens of drug administration
Yan 2000	Not eligible intervention
Yang 2001	Not eligible intervention
Young 1988	Not eligible intervention
Zamora 1999	Same drug intervention both arms and only different timings of drug administration
Zaporozhan 2013	Not eligible intervention
Zhao 1998	Not eligible intervention
Zhao 2003	Not eligible intervention
Zhou 1994	Same drug intervention both arms and only different routes of drug administration

PPH: postpartum haemorrhage

Characteristics of studies awaiting assessment *[ordered by study ID]*

Abdel-Aleem 1997

Methods	Randomised trial
Participants	High-risk women after vaginal delivery in Assiut, Egypt.
Interventions	Carboprost 250 mcg IM versus methylergonovine maleate 0.4 mg IV versus oxytocin 10 IU IV
Outcomes	Blood loss
Notes	Abstract only and awaiting reply from authors for additional information or full text

Alli 2013

Methods	Randomised double-blinded trial.
Participants	Women undergoing caesareans.
Interventions	Sublingual misoprostol 600 mcg or 10 IU bolus intravenous oxytocin
Outcomes	Blood loss, need for additional uterotonics, and side effects
Notes	Abstract only and unable to contact authors for additional information or full text

Amornpetchakul 2017

Methods	Randomised controlled trial
Participants	Women undergoing vaginal delivery in high-risk singleton pregnancies
Interventions	5 IU of oxytocin or 100 mcg of carbetocin intravenously.
Outcomes	Blood loss, PPH, additional uterotonics.
Notes	Abstract only and awaiting reply from authors for additional information or full text

Beigi 2009

Methods	Randomised trial.
Participants	542 nulliparous pregnant women
Interventions	20 IU of oxytocin administered intravenously or 400 mcg of misoprostol administered sublingually
Outcomes	PPH (not defined), third-stage duration (minutes), headache, shivering

Notes	Method of randomisation not clear and 'Risk of bias' assessment is uncertain. Written in Persian and awaiting translation

Muller 1996

Methods	Randomised trial
Participants	Women with singleton pregnancies in hospital setting
Interventions	Oxytocin 5 IU IV versus no treatment
Outcomes	Change in Hb level
Notes	Abstract only and unable to contact authors for additional information or full text

Norchi 1988

Methods	Controlled clinical trial
Participants	No details available
Interventions	Sulprostone versus methylergometrine
Outcomes	No details available
Notes	Abstract only and unable to contact authors for additional information or full text

Rabow 2017

Methods	Randomised trial
Participants	Healthy, singleton pregnant women undergoing elective caesarean section in spinal anaesthesia
Interventions	Carbetocin 100 mcg IV versus oxytocin 5 IU IV
Outcomes	Cardiovascular parameters and need for additional uterotonics
Notes	Abstract only and awaiting reply from authors for additional information or full text

Roy 2017

Methods	Randomised trial
Participants	Women in the third stage of labour
Interventions	Misoprostol 400 mcg PO versus oxytocin 10 IU IM
Outcomes	Blood loss, postpartum Hb and side effects
Notes	Abstract only and unable to contact authors for additional information or full text

Said 2017

Methods	Randomised trial
Participants	Women undergoing elective caesareans
Interventions	Misoprostol 600 mcg PR versus oxytocin unspecified dose IV
Outcomes	Blood loss and postpartum Hb
Notes	Abstract only and unable to contact authors for additional information or full text

Shrivasatava 2012

Methods	Randomised trial.
Participants	Not known how many women randomised
Interventions	200 mcg of methylergometrine of unknown route or 400 mcg of misoprostol administered sublingually
Outcomes	PPH (not defined), additional uterotonics, change in Hb level, third-stage duration (minutes), blood loss (mL)
Notes	Method of randomisation not clear and 'Risk of bias' assessment is uncertain. Abstract only. Unable to contact authors

Sunil 2016

Methods	Randomised trial.
Participants	Women at term with spontaneous onset of labour
Interventions	Oxytocin 10 IU IM versus carboprost tromethamine 125 mcg IM
Outcomes	Blood loss, PPH, diarrhoea
Notes	Method of randomisation not clear and 'Risk of bias' assessment is uncertain. Abstract only. Unable to contact authors

Hb: haemoglobin; **IM:** intramuscular; **IU:** international unit;**IV:** intravascular; **mcg:** microgram; **mL:**: millilitre; **PO:** by mouth; **PPH:** postpartum haemorrhage; **PR:** rectally.

Characteristics of ongoing studies *[ordered by study ID]*

Balki 2017

Trial name or title	Carbetocin versus oxytocin at elective cesarean section: a double-blind, randomized controlled non-inferiority trial of high and low dose regimens
Methods	Randomised double-blinded
Participants	Women undergoing elective caesareans.
Interventions	Carbetocin 20 mcg IV versus carbetocin 100 mcg IV versus oxytocin 0.5 IU IV versus oxytocin 5 IU IV
Outcomes	Additional uterotonics, side effects
Starting date	May 25, 2017
Contact information	Mrinalini Balki, Samuel Lunenfeld Research Institute, Mount Sinai Hospital
Notes	Recruiting

Draycott 2014

Trial name or title	Intramuscular oxytocics: a comparison study of intramuscular carbetocin, syntocinon and syntometrine for the third stage of labour following vaginal birth (IMox)
Methods	Randomised trial
Participants	Women delivering vaginally, singleton pregnancy
Interventions	1 dose of 100 mcg intramuscular carbetocin given for active management of the third stage of labour, immediately after the birth of the baby 1 dose of 10 IU intramuscular syntocinon given for active management of the third stage of labour, immediately after the birth of the baby 1 dose of 500 mcg/5 IU intramuscular Ssyntometrine® given for active management of the third stage of labour, immediately after the birth of the baby
Outcomes	Use of additional uterotonic agents
Starting date	February 2015
Contact information	Tim Draycott, North Bristol NHS Trust/University of Bristol
Notes	Study Chair:

Gomez 2011

Trial name or title	Efficiency of carbetocin in the prevention of the postpartum haemorrhage: a clinical double-blinded randomised study
Methods	Open-label randomised trial.
Participants	Women undergoing a vaginal birth at home with a trained study provider
Interventions	600 mcg of misoprostol administered orally or 10 IU of oxytocin administered intramuscularly
Outcomes	PPH at 1000, additional uterotonics, transfusion, nausea, headache, abdominal pain
Starting date	15/07/2010
Contact information	Milton Cesar Gomez Gomez
Notes	This study is shown as not yet recruiting.

Goudar 2016

Trial name or title	Room temperature stable carbetocin for preventing blood loss after delivery
Methods	Randomised, parallel group, active controlled trial
Participants	Pregnant women and women who have had a vaginal birth
Interventions	Carbetocin RTS 100 mcg IM versus oxytocin 10 IU IM
Outcomes	Primary: post-delivery (48-72 hours) Hb level adjusted for pre-delivery haemoglobin Secondary: 1 Blood loss of 500 mL or more within 1 hour 2 Blood loss of 1000 mL or more within 1 hour 3 Additional uterotonics 4 Blood transfusion 5 Manual removal of placenta 6 Additional surgical procedures 7 Maternal death 8 Composite outcome of maternal death or severe morbidity up to time of discharge 9 Incidence and severity of adverse or serious adverse events up to time of discharge
Starting date	01/07/2016
Contact information	Dr Shivaprasad S Goudar Womens and Childrens Health Research Unit KLE Universitys J N Medical College Nehru Nagar Belgaum KARNATAKA 590010 India

Goudar 2016 (*Continued*)

Notes	Completed but results not available to date

Kalahroudi 2010a

Trial name or title	Comparison of the effect of rectal misoprostol and syntometrin in prevention of postpartum hemorrhage
Methods	Double-blinded randomised trial.
Participants	200 women with a singleton pregnancy undergoing a vaginal birth
Interventions	500 mcg of ergometrine plus 5 IU of oxytocin administered intramuscularly or 600 mcg of misoprostol administered rectally
Outcomes	Additional uterotonics, change in Hb level.
Starting date	21/4/2010
Contact information	Dr Mansoureh Samimi
Notes	This study is shown as recruitment complete.

Kalahroudi 2010b

Trial name or title	Comparison effect of carbetocine and syntometrin in prevention of postpartum hemorrhage
Methods	Double-blinded randomised trial.
Participants	200 women with a singleton pregnancy undergoing a vaginal birth
Interventions	500 mcg of ergometrine plus 5 IU of oxytocin administered intramuscularly or 100 mcg of carbetocin administered intramuscularly
Outcomes	Additional uterotonics, change in Hb level.
Starting date	21/1/2010
Contact information	Dr Mansoureh Samimi
Notes	This study is shown as recruitment complete.

Maged 2018

Trial name or title	Carbetocin versus rectal misoprostol for management of third stage of labor in women at low risk of postpartum hemorrhage
Methods	Interventional (clinical trial)
Participants	Women admitted for spontaneous, induced or augmented vaginal delivery and categorized as low risk for PPH
Interventions	Carbetocin 100 mcg IV versus misoprostol 800 mcg PR
Outcomes	Prevention of PPH after vaginal delivery and side effects
Starting date	July 2, 2017
Contact information	Ahmed Maged, Cairo University
Notes	Completed but no results posted

Moradi 2010

Trial name or title	Comparison of misoprostol and oxytocin in reduction of postpartum hemorrhage
Methods	Randomised trial.
Participants	300 women with singleton, term pregnancies.
Interventions	10 IU of oxytocin administered intravenously or 400 mcg of misoprostol administered orally
Outcomes	Change in Hb.
Starting date	22/12/2009
Contact information	Simindokht Moradi
Notes	This study is shown as recruitment complete.

Sweed 2014

Trial name or title	Comparison between rectal and sublingual misoprostol before caesarian section to reduce intra and post-operative blood loss
Methods	Placebo-controlled randomised trial.
Participants	635 women undergoing elective caesarean with a singleton term pregnancy and only 1 previous caesarean
Interventions	400 mcg of misoprostol administered rectally or 400 mcg of misoprostol administered sublingually or placebo

Sweed 2014 (*Continued*)

Outcomes	Change in Hb level, blood loss.
Starting date	February 2013
Contact information	Mohamed S Sweed
Notes	Completed but no report available.

Thakur 2015

Trial name or title	A clinical trial to compare the effects of 4 drugs, oxytocin, misoprostol, 15-methylprostaglandinF2alpha and methylergometrine in active management of third stage of labor
Methods	Randomised, parallel group, multiple-arm trial
Participants	All non high-risk women at term pregnancy (37 to 40 weeks of gestation) who delivered vaginally
Interventions	Oxytocin 10 IU IM versus misoprostol 600 mcg PR versus 15-methyl prostaglandin F2alpha 125 mcg IM versus methylergometrine 200 mcg IM
Outcomes	Blood loss, PPH, blood transfusion, need for additional uterotonics, side effects
Starting date	01/01/2013
Contact information	Dr Priyanka Thakur
Notes	Completed but no report available

Hb: haemoglobin; **IM:** intramuscular; **IU:** international unit;**IV:** intravenous; **mcg:** microgram; **PPH:** postpartum haemorrhage; **PR:** rectally; **RTS:** room temperature stable

DATA AND ANALYSES

Comparison 1. Oxytocin vs Placebo or no treatment

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	3	1920	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	11	8782	Risk Ratio (IV, Random, 95% CI)	0.61 [0.52, 0.73]
3 Blood transfusion	8	6717	Risk Ratio (IV, Random, 95% CI)	0.75 [0.51, 1.12]
4 Severe maternal morbidity: intensive care admissions	1	1950	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	9	7021	Risk Ratio (IV, Random, 95% CI)	0.61 [0.52, 0.71]
7 Additional uterotonics	8	5047	Risk Ratio (IV, Random, 95% CI)	0.43 [0.32, 0.58]
8 Blood loss	8	3521	Mean Difference (IV, Random, 95% CI)	-118.52 [-141.40, -95.64]
9 Change in haemoglobin	5	2304	Mean Difference (IV, Random, 95% CI)	-2.68 [-4.47, -0.89]
10 Breastfeeding	1	1540	Risk Ratio (IV, Random, 95% CI)	1.00 [0.95, 1.05]
11 Nausea	3	1788	Risk Ratio (IV, Random, 95% CI)	0.82 [0.47, 1.42]
12 Vomiting	3	2150	Risk Ratio (IV, Random, 95% CI)	1.40 [0.44, 4.41]
13 Headache	2	1704	Risk Ratio (IV, Random, 95% CI)	1.56 [0.52, 4.74]
14 Abdominal pain	1	1665	Risk Ratio (IV, Random, 95% CI)	0.89 [0.80, 1.00]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	1	416	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	1	416	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal sense of well-being	1		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Women's perceptions of well-being at 3 months postpartum: less energy than before birth	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Women's perceptions of well-being at 3 months postpartum: experiencing (some) fatigue	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	1		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Did management influence positively the childbirth experiences of the mothers?	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Did management influence negatively the childbirth experiences of the mothers?	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.3 Did management make no difference in the childbirth experiences of the mothers?	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 2. Carbetocin vs Placebo or no treatment

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	50	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	50	Risk Ratio (IV, Random, 95% CI)	0.75 [0.30, 1.85]
7 Additional uterotonics	2	169	Risk Ratio (IV, Random, 95% CI)	0.19 [0.12, 0.32]
8 Blood loss	1	50	Mean Difference (IV, Random, 95% CI)	-274.0 [-591.60, 43.60]
9 Change in haemoglobin	1	50	Mean Difference (IV, Random, 95% CI)	-3.40 [-7.23, 0.43]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	1	50	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 3. Misoprostol vs Placebo or no treatment

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	4	3497	Risk Ratio (IV, Random, 95% CI)	1.00 [0.10, 9.59]
2 PPH >= 1000 mL	8	5467	Risk Ratio (IV, Random, 95% CI)	0.73 [0.56, 0.95]
3 Blood transfusion	6	3134	Risk Ratio (IV, Random, 95% CI)	0.46 [0.15, 1.47]
4 Severe maternal morbidity: intensive care admissions	1	1620	Risk Ratio (IV, Random, 95% CI)	1.00 [0.14, 7.05]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	7	4047	Risk Ratio (IV, Random, 95% CI)	0.75 [0.59, 0.94]
7 Additional uterotonics	8	3746	Risk Ratio (IV, Random, 95% CI)	0.67 [0.52, 0.87]
8 Blood loss	8	4146	Mean Difference (IV, Random, 95% CI)	-42.07 [-52.47, -31.68]
9 Change in haemoglobin	5	2334	Mean Difference (IV, Random, 95% CI)	-2.53 [-3.53, -1.52]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	4	3997	Risk Ratio (IV, Random, 95% CI)	1.18 [0.78, 1.78]
12 Vomiting	6	4949	Risk Ratio (IV, Random, 95% CI)	1.41 [0.92, 2.16]

13 Headache	1	1116	Risk Ratio (IV, Random, 95% CI)	0.94 [0.32, 2.77]
14 Abdominal pain	4	1894	Risk Ratio (IV, Random, 95% CI)	0.98 [0.29, 3.37]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	9	5286	Risk Ratio (IV, Random, 95% CI)	2.94 [2.38, 3.64]
17 Fever	5	4396	Risk Ratio (IV, Random, 95% CI)	4.09 [2.01, 8.32]
18 Diarrhoea	6	4791	Risk Ratio (IV, Random, 95% CI)	2.80 [1.21, 6.49]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 4. Injectable prostaglandins vs Placebo or no treatment

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	46	Risk Ratio (IV, Random, 95% CI)	0.36 [0.04, 3.24]
3 Blood transfusion	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	46	Risk Ratio (IV, Random, 95% CI)	0.55 [0.22, 1.35]
7 Additional uterotonics	2	146	Risk Ratio (IV, Random, 95% CI)	0.66 [0.21, 2.09]
8 Blood loss	2	146	Mean Difference (IV, Random, 95% CI)	-95.17 [-296.09, 105.75]
9 Change in haemoglobin	1	100	Mean Difference (IV, Random, 95% CI)	0.90 [0.56, 1.24]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	46	Risk Ratio (IV, Random, 95% CI)	0.36 [0.02, 8.46]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 5. Ergometrine vs Placebo or no treatment

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	1429	Risk Ratio (IV, Random, 95% CI)	0.09 [0.01, 0.72]
3 Blood transfusion	2	1529	Risk Ratio (IV, Random, 95% CI)	0.34 [0.04, 3.28]

4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	1429	Risk Ratio (IV, Random, 95% CI)	0.24 [0.14, 0.42]
7 Additional uterotonics	2	1529	Risk Ratio (IV, Random, 95% CI)	0.18 [0.09, 0.37]
8 Blood loss	2	1529	Mean Difference (IV, Random, 95% CI)	-50.64 [-119.92, 18.65]
9 Change in haemoglobin	1	100	Mean Difference (IV, Random, 95% CI)	-0.5 [-0.58, -0.42]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	1429	Risk Ratio (IV, Random, 95% CI)	42.10 [2.55, 694.80]
12 Vomiting	1	1429	Risk Ratio (IV, Random, 95% CI)	25.67 [1.52, 432.78]
13 Headache	1	1429	Risk Ratio (IV, Random, 95% CI)	7.19 [0.37, 138.91]
14 Abdominal pain	1	1429	Risk Ratio (IV, Random, 95% CI)	2.05 [1.04, 4.08]
15 Hypertension	1	1429	Risk Ratio (IV, Random, 95% CI)	7.19 [2.83, 18.24]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 6. Ergometrine plus oxytocin vs Placebo or no treatment

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	3207	Risk Ratio (IV, Random, 95% CI)	0.44 [0.18, 1.05]
3 Blood transfusion	3	3400	Risk Ratio (IV, Random, 95% CI)	0.34 [0.18, 0.66]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	2	3207	Risk Ratio (IV, Random, 95% CI)	0.37 [0.30, 0.46]
7 Additional uterotonics	3	3400	Risk Ratio (IV, Random, 95% CI)	0.19 [0.15, 0.24]
8 Blood loss	2	1705	Mean Difference (IV, Random, 95% CI)	-35.02 [-101.63, 31.59]
9 Change in haemoglobin	2	1454	Mean Difference (IV, Random, 95% CI)	-3.57 [-6.50, -0.63]
10 Breastfeeding	2	3207	Risk Ratio (IV, Random, 95% CI)	1.03 [0.99, 1.07]
11 Nausea	1	1512	Risk Ratio (IV, Random, 95% CI)	1.95 [1.38, 2.76]
12 Vomiting	2	3207	Risk Ratio (IV, Random, 95% CI)	2.15 [1.46, 3.18]
13 Headache	2	3207	Risk Ratio (IV, Random, 95% CI)	1.65 [0.78, 3.48]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	1		Risk Ratio (IV, Random, 95% CI)	Totals not selected

19.1 General health at 6 weeks postpartum (Worse than prepregnancy)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 General health at 6 weeks postpartum (Exhausted since birth)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.3 General health at 6 weeks postpartum (Exhausted at 6 weeks)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.4 General health at 6 weeks postpartum (Blues)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.5 General health at 6 weeks postpartum (Depressed)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.6 General health at 6 weeks postpartum (Help for depression)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.7 General health at 6 weeks postpartum (Admission to hospital for depression)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.8 General health at 6 weeks postpartum (No health problems reported)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	1	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Satisfied with third-stage management	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Felt in control during third stage	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 7. Misoprostol plus oxytocin vs Placebo or no treatment

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 8. Misoprostol vs Oxytocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	24	28520	Risk Ratio (IV, Random, 95% CI)	0.62 [0.14, 2.74]
2 PPH >= 1000 mL	38	34261	Risk Ratio (IV, Random, 95% CI)	1.26 [1.11, 1.43]
3 Blood transfusion	42	35467	Risk Ratio (IV, Random, 95% CI)	0.81 [0.65, 1.00]
4 Severe maternal morbidity: intensive care admissions	10	21698	Risk Ratio (IV, Random, 95% CI)	1.16 [0.55, 2.43]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	44	36920	Risk Ratio (IV, Random, 95% CI)	1.08 [0.94, 1.24]
7 Additional uterotonics	47	35981	Risk Ratio (IV, Random, 95% CI)	1.01 [0.85, 1.20]
8 Blood loss	43	35239	Mean Difference (IV, Random, 95% CI)	-8.90 [-23.45, 5.65]
9 Change in haemoglobin	31	12028	Mean Difference (IV, Random, 95% CI)	-0.14 [-0.74, 0.47]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	33	29732	Risk Ratio (IV, Random, 95% CI)	1.22 [0.93, 1.60]
12 Vomiting	41	32687	Risk Ratio (IV, Random, 95% CI)	1.51 [1.19, 1.91]
13 Headache	10	4079	Risk Ratio (IV, Random, 95% CI)	0.88 [0.54, 1.42]
14 Abdominal pain	8	3382	Risk Ratio (IV, Random, 95% CI)	0.91 [0.79, 1.06]
15 Hypertension	3	1028	Risk Ratio (IV, Random, 95% CI)	3.64 [0.60, 22.27]
16 Shivering	49	34865	Risk Ratio (IV, Random, 95% CI)	4.02 [3.23, 4.99]
17 Fever	41	33008	Risk Ratio (IV, Random, 95% CI)	3.75 [2.73, 5.15]
18 Diarrhoea	26	30733	Risk Ratio (IV, Random, 95% CI)	2.13 [1.55, 2.93]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	1		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Satisfied or very satisfied with drug	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Complaints about or problems with drug	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.3 Would take drug again after subsequent deliveries	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.4 Would recommend drug to a friend	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 9. Injectable prostaglandins vs Oxytocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	200	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	100	Risk Ratio (IV, Random, 95% CI)	1.43 [0.20, 10.31]
3 Blood transfusion	2	250	Risk Ratio (IV, Random, 95% CI)	1.01 [0.04, 23.65]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	4	500	Risk Ratio (IV, Random, 95% CI)	0.84 [0.26, 2.71]
7 Additional uterotonics	4	500	Risk Ratio (IV, Random, 95% CI)	0.29 [0.09, 0.94]
8 Blood loss	4	500	Mean Difference (IV, Random, 95% CI)	-15.83 [-152.28, 120.62]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	3	450	Risk Ratio (IV, Random, 95% CI)	1.17 [0.40, 3.41]
12 Vomiting	2	400	Risk Ratio (IV, Random, 95% CI)	2.48 [0.57, 10.73]
13 Headache	1	200	Risk Ratio (IV, Random, 95% CI)	0.20 [0.01, 4.11]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	2	400	Risk Ratio (IV, Random, 95% CI)	0.91 [0.11, 7.73]
17 Fever	1	200	Risk Ratio (IV, Random, 95% CI)	2.0 [0.18, 21.71]
18 Diarrhoea	2	400	Risk Ratio (IV, Random, 95% CI)	10.38 [1.96, 54.98]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 10. Carbetocin vs Oxytocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	5	30327	Risk Ratio (IV, Random, 95% CI)	2.00 [0.37, 10.92]
2 PPH >= 1000 mL	10	30633	Risk Ratio (IV, Random, 95% CI)	0.73 [0.45, 1.19]
3 Blood transfusion	16	32115	Risk Ratio (IV, Random, 95% CI)	0.68 [0.38, 1.22]
4 Severe maternal morbidity: intensive care admissions	2	29847	Risk Ratio (IV, Random, 95% CI)	1.16 [0.67, 2.02]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	11	30633	Risk Ratio (IV, Random, 95% CI)	0.75 [0.58, 0.98]
7 Additional uterotonics	22	32699	Risk Ratio (IV, Random, 95% CI)	0.48 [0.34, 0.68]
8 Blood loss	16	2115	Mean Difference (IV, Random, 95% CI)	-92.73 [-154.97, -30.49]
9 Change in haemoglobin	12	2096	Mean Difference (IV, Random, 95% CI)	-1.66 [-3.81, 0.50]
10 Breastfeeding	2	190	Risk Ratio (IV, Random, 95% CI)	0.94 [0.86, 1.03]
11 Nausea	12	2288	Risk Ratio (IV, Random, 95% CI)	1.11 [0.78, 1.56]
12 Vomiting	13	31833	Risk Ratio (IV, Random, 95% CI)	0.90 [0.53, 1.50]

13 Headache	15	2620	Risk Ratio (IV, Random, 95% CI)	0.84 [0.63, 1.12]
14 Abdominal pain	10	31293	Risk Ratio (IV, Random, 95% CI)	1.18 [0.97, 1.44]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	9	1998	Risk Ratio (IV, Random, 95% CI)	0.78 [0.49, 1.23]
17 Fever	4	466	Risk Ratio (IV, Random, 95% CI)	1.58 [0.27, 9.35]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 11. Ergometrine vs Oxytocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	1293	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	6	2591	Risk Ratio (IV, Random, 95% CI)	1.30 [0.52, 3.27]
3 Blood transfusion	5	1893	Risk Ratio (IV, Random, 95% CI)	1.44 [0.20, 10.23]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	10	3221	Risk Ratio (IV, Random, 95% CI)	1.31 [0.86, 1.99]
7 Additional uterotonics	6	2493	Risk Ratio (IV, Random, 95% CI)	1.46 [0.61, 3.48]
8 Blood loss	10	3221	Mean Difference (IV, Random, 95% CI)	8.09 [-17.83, 34.00]
9 Change in haemoglobin	2	1893	Mean Difference (IV, Random, 95% CI)	0.42 [-0.30, 1.13]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	6	2529	Risk Ratio (IV, Random, 95% CI)	4.56 [1.13, 18.44]
12 Vomiting	5	2343	Risk Ratio (IV, Random, 95% CI)	3.83 [1.10, 13.28]
13 Headache	4	2293	Risk Ratio (IV, Random, 95% CI)	5.63 [0.93, 33.96]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	3	1410	Risk Ratio (IV, Random, 95% CI)	13.39 [2.01, 89.44]
16 Shivering	3	1493	Risk Ratio (IV, Random, 95% CI)	1.73 [0.93, 3.25]
17 Fever	2	1443	Risk Ratio (IV, Random, 95% CI)	2.97 [0.97, 9.05]
18 Diarrhoea	2	1393	Risk Ratio (IV, Random, 95% CI)	3.74 [0.42, 33.53]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 12. Ergometine plus oxytocin vs Oxytocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	2	1314	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	10	10990	Risk Ratio (IV, Random, 95% CI)	0.73 [0.57, 0.93]
3 Blood transfusion	11	10985	Risk Ratio (IV, Random, 95% CI)	0.88 [0.53, 1.44]
4 Severe maternal morbidity: intensive care admissions	1	991	Risk Ratio (IV, Random, 95% CI)	2.99 [0.12, 73.32]

5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	11	11090	Risk Ratio (IV, Random, 95% CI)	0.72 [0.57, 0.91]
7 Additional uterotonics	10	8968	Risk Ratio (IV, Random, 95% CI)	0.79 [0.59, 1.07]
8 Blood loss	10	4248	Mean Difference (IV, Random, 95% CI)	-10.31 [-40.32, 19.70]
9 Change in haemoglobin	6	4324	Mean Difference (IV, Random, 95% CI)	-2.23 [-5.24, 0.77]
10 Breastfeeding	1	3483	Risk Ratio (IV, Random, 95% CI)	0.99 [0.96, 1.01]
11 Nausea	7	6931	Risk Ratio (IV, Random, 95% CI)	1.72 [0.84, 3.53]
12 Vomiting	9	10227	Risk Ratio (IV, Random, 95% CI)	3.05 [1.76, 5.29]
13 Headache	5	5105	Risk Ratio (IV, Random, 95% CI)	1.26 [0.79, 1.99]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	3	1362	Risk Ratio (IV, Random, 95% CI)	2.00 [0.29, 13.97]
16 Shivering	2	1591	Risk Ratio (IV, Random, 95% CI)	0.96 [0.60, 1.53]
17 Fever	2	1591	Risk Ratio (IV, Random, 95% CI)	1.08 [0.48, 2.43]
18 Diarrhoea	3	2030	Risk Ratio (IV, Random, 95% CI)	1.26 [0.72, 2.22]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 13. Misoprostol plus oxytocin vs Oxytocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	9	4737	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	17	8514	Risk Ratio (IV, Random, 95% CI)	0.87 [0.69, 1.09]
3 Blood transfusion	19	8742	Risk Ratio (IV, Random, 95% CI)	0.50 [0.37, 0.67]
4 Severe maternal morbidity: intensive care admissions	3	1886	Risk Ratio (IV, Random, 95% CI)	0.50 [0.05, 5.47]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	14	8148	Risk Ratio (IV, Random, 95% CI)	0.71 [0.59, 0.85]
7 Additional uterotonics	18	8391	Risk Ratio (IV, Random, 95% CI)	0.54 [0.44, 0.67]
8 Blood loss	17	8690	Mean Difference (IV, Random, 95% CI)	-87.26 [-157.83, -16.69]
9 Change in haemoglobin	15	7929	Mean Difference (IV, Random, 95% CI)	-2.59 [-3.70, -1.48]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	7	3798	Risk Ratio (IV, Random, 95% CI)	2.21 [1.19, 4.10]
12 Vomiting	11	6718	Risk Ratio (IV, Random, 95% CI)	2.24 [1.52, 3.31]
13 Headache	2	303	Risk Ratio (IV, Random, 95% CI)	1.26 [0.26, 6.23]
14 Abdominal pain	1	366	Risk Ratio (IV, Random, 95% CI)	1.93 [1.01, 3.67]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	19	9458	Risk Ratio (IV, Random, 95% CI)	3.38 [2.50, 4.57]
17 Fever	17	8607	Risk Ratio (IV, Random, 95% CI)	2.99 [2.00, 4.45]
18 Diarrhoea	7	5649	Risk Ratio (IV, Random, 95% CI)	2.08 [0.99, 4.38]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 14. Injectable prostaglandins vs Misoprostol

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	170	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
3 Blood transfusion	4	403	Risk Ratio (IV, Random, 95% CI)	0.88 [0.14, 5.39]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	3	303	Risk Ratio (IV, Random, 95% CI)	1.60 [0.57, 4.52]
7 Additional uterotonics	4	403	Risk Ratio (IV, Random, 95% CI)	1.02 [0.28, 3.69]
8 Blood loss	3	270	Mean Difference (IV, Random, 95% CI)	52.99 [-39.74, 145.71]
9 Change in haemoglobin	2	220	Mean Difference (IV, Random, 95% CI)	2.28 [-1.35, 5.90]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	2	233	Risk Ratio (IV, Random, 95% CI)	0.23 [0.06, 0.92]
12 Vomiting	2	233	Risk Ratio (IV, Random, 95% CI)	1.31 [0.01, 163.15]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	2	233	Risk Ratio (IV, Random, 95% CI)	0.99 [0.20, 4.80]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	3	353	Risk Ratio (IV, Random, 95% CI)	0.04 [0.01, 0.21]
17 Fever	2	233	Risk Ratio (IV, Random, 95% CI)	0.08 [0.01, 0.39]
18 Diarrhoea	2	233	Risk Ratio (IV, Random, 95% CI)	9.03 [1.70, 48.00]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 15. Misoprostol vs Carbetocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	177	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	177	Risk Ratio (IV, Random, 95% CI)	2.31 [0.62, 8.64]
3 Blood transfusion	1	177	Risk Ratio (IV, Random, 95% CI)	2.97 [0.12, 71.85]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	177	Risk Ratio (IV, Random, 95% CI)	2.31 [1.52, 3.50]
7 Additional uterotonics	1	177	Risk Ratio (IV, Random, 95% CI)	3.96 [1.55, 10.07]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	177	Risk Ratio (IV, Random, 95% CI)	0.99 [0.47, 2.08]
12 Vomiting	1	177	Risk Ratio (IV, Random, 95% CI)	1.48 [0.55, 3.99]
13 Headache	1	177	Risk Ratio (IV, Random, 95% CI)	1.19 [0.71, 1.99]

14 Abdominal pain	1	177	Risk Ratio (IV, Random, 95% CI)	0.65 [0.52, 0.80]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	1	177	Risk Ratio (IV, Random, 95% CI)	3.46 [1.67, 7.17]
17 Fever	1	177	Risk Ratio (IV, Random, 95% CI)	2.55 [1.41, 4.64]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 16. Ergometrine vs Misoprostol

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	7	5254	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	11	5562	Risk Ratio (IV, Random, 95% CI)	1.25 [0.45, 3.48]
3 Blood transfusion	13	5308	Risk Ratio (IV, Random, 95% CI)	1.71 [0.65, 4.50]
4 Severe maternal morbidity: intensive care admissions	1	864	Risk Ratio (IV, Random, 95% CI)	0.33 [0.01, 8.16]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	16	6459	Risk Ratio (IV, Random, 95% CI)	1.18 [0.79, 1.75]
7 Additional uterotonics	16	6565	Risk Ratio (IV, Random, 95% CI)	1.04 [0.68, 1.60]
8 Blood loss	15	6337	Mean Difference (IV, Random, 95% CI)	11.66 [-9.85, 33.17]
9 Change in haemoglobin	8	4438	Mean Difference (IV, Random, 95% CI)	0.91 [-0.43, 2.26]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	13	5202	Risk Ratio (IV, Random, 95% CI)	1.53 [1.15, 2.04]
12 Vomiting	14	6136	Risk Ratio (IV, Random, 95% CI)	1.22 [0.81, 1.83]
13 Headache	8	3369	Risk Ratio (IV, Random, 95% CI)	1.70 [0.70, 4.12]
14 Abdominal pain	2	233	Risk Ratio (IV, Random, 95% CI)	1.58 [0.04, 65.80]
15 Hypertension	2	300	Risk Ratio (IV, Random, 95% CI)	7.55 [0.94, 60.53]
16 Shivering	17	6860	Risk Ratio (IV, Random, 95% CI)	0.34 [0.26, 0.44]
17 Fever	14	6330	Risk Ratio (IV, Random, 95% CI)	0.24 [0.17, 0.33]
18 Diarrhoea	8	4165	Risk Ratio (IV, Random, 95% CI)	1.04 [0.46, 2.34]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 17. Misoprostol vs Ergometrine plus oxytocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	4	3258	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	9	6028	Risk Ratio (IV, Random, 95% CI)	1.61 [1.08, 2.40]
3 Blood transfusion	8	6335	Risk Ratio (IV, Random, 95% CI)	1.41 [0.91, 2.21]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	10	6492	Risk Ratio (IV, Random, 95% CI)	1.75 [1.35, 2.26]
7 Additional uterotonics	9	6395	Risk Ratio (IV, Random, 95% CI)	1.87 [1.49, 2.36]
8 Blood loss	8	5634	Mean Difference (IV, Random, 95% CI)	22.86 [4.50, 41.22]
9 Change in haemoglobin	9	5588	Mean Difference (IV, Random, 95% CI)	1.09 [-0.49, 2.67]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	4	3399	Risk Ratio (IV, Random, 95% CI)	0.71 [0.61, 0.84]
12 Vomiting	6	4983	Risk Ratio (IV, Random, 95% CI)	0.72 [0.50, 1.04]
13 Headache	3	3259	Risk Ratio (IV, Random, 95% CI)	0.91 [0.47, 1.76]
14 Abdominal pain	1	846	Risk Ratio (IV, Random, 95% CI)	0.90 [0.79, 1.02]
15 Hypertension	3	2553	Risk Ratio (IV, Random, 95% CI)	0.50 [0.18, 1.41]
16 Shivering	6	4980	Risk Ratio (IV, Random, 95% CI)	2.71 [1.95, 3.76]
17 Fever	7	5045	Risk Ratio (IV, Random, 95% CI)	5.33 [2.87, 9.88]
18 Diarrhoea	6	3659	Risk Ratio (IV, Random, 95% CI)	1.04 [0.68, 1.57]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	1		Mean Difference (IV, Random, 95% CI)	Totals not selected
20.1 Woman's satisfaction using an eight item Client Satisfaction Questionnaire	1		Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 18. Misoprostol vs Misoprostol plus oxytocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	1589	Risk Ratio (IV, Random, 95% CI)	1.85 [1.03, 3.33]
3 Blood transfusion	2	1589	Risk Ratio (IV, Random, 95% CI)	2.97 [1.40, 6.30]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	2	1589	Risk Ratio (IV, Random, 95% CI)	1.93 [0.99, 3.76]
7 Additional uterotonics	3	1689	Risk Ratio (IV, Random, 95% CI)	1.89 [1.26, 2.83]
8 Blood loss	1	792	Mean Difference (IV, Random, 95% CI)	48.0 [24.68, 71.32]
9 Change in haemoglobin	3	1689	Mean Difference (IV, Random, 95% CI)	0.27 [-0.42, 0.96]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	100	Risk Ratio (IV, Random, 95% CI)	1.83 [0.73, 4.57]
12 Vomiting	3	1689	Risk Ratio (IV, Random, 95% CI)	1.39 [0.51, 3.82]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	3	1689	Risk Ratio (IV, Random, 95% CI)	0.94 [0.72, 1.22]
17 Fever	3	1689	Risk Ratio (IV, Random, 95% CI)	0.97 [0.62, 1.53]
18 Diarrhoea	2	1589	Risk Ratio (IV, Random, 95% CI)	1.22 [0.70, 2.13]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 19. Carbetocin vs Injectable prostaglandins

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 20. Injectable prostaglandins vs Ergometrine

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	50	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
3 Blood transfusion	4	384	Risk Ratio (IV, Random, 95% CI)	1.01 [0.04, 23.58]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	3	399	Risk Ratio (IV, Random, 95% CI)	1.42 [0.64, 3.17]
7 Additional uterotonics	5	684	Risk Ratio (IV, Random, 95% CI)	0.78 [0.40, 1.51]
8 Blood loss	8	1195	Mean Difference (IV, Random, 95% CI)	-16.08 [-57.17, 25.00]
9 Change in haemoglobin	2	300	Mean Difference (IV, Random, 95% CI)	-1.28 [-6.58, 4.01]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	5	684	Risk Ratio (IV, Random, 95% CI)	1.70 [0.98, 2.94]
12 Vomiting	5	684	Risk Ratio (IV, Random, 95% CI)	2.70 [0.97, 7.55]
13 Headache	1	80	Risk Ratio (IV, Random, 95% CI)	2.0 [0.39, 10.31]

14 Abdominal pain	3	384	Risk Ratio (IV, Random, 95% CI)	1.70 [0.07, 40.44]
15 Hypertension	2	315	Risk Ratio (IV, Random, 95% CI)	0.16 [0.02, 1.37]
16 Shivering	3	434	Risk Ratio (IV, Random, 95% CI)	0.38 [0.16, 0.91]
17 Fever	4	534	Risk Ratio (IV, Random, 95% CI)	4.52 [0.76, 26.80]
18 Diarrhoea	5	664	Risk Ratio (IV, Random, 95% CI)	10.09 [2.75, 37.00]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 21. Injectable prostaglandins vs Ergometrine plus oxytocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	598	Risk Ratio (IV, Random, 95% CI)	0.80 [0.17, 3.78]
3 Blood transfusion	1	69	Risk Ratio (IV, Random, 95% CI)	0.65 [0.17, 2.53]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	2	598	Risk Ratio (IV, Random, 95% CI)	1.29 [0.92, 1.79]
7 Additional uterotonics	1	112	Risk Ratio (IV, Random, 95% CI)	1.07 [0.16, 7.36]
8 Blood loss	2	598	Mean Difference (IV, Random, 95% CI)	-26.18 [-104.63, 52.27]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	529	Risk Ratio (IV, Random, 95% CI)	5.06 [1.12, 22.86]
12 Vomiting	1	529	Risk Ratio (IV, Random, 95% CI)	0.92 [0.40, 2.13]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	2	641	Risk Ratio (IV, Random, 95% CI)	23.70 [7.55, 74.45]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 22. Misoprostol plus oxytocin vs Injectable prostaglandins

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 23. Ergometrine vs Carbetocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 24. Carbetocin vs Ergometrine plus oxytocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	2	320	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	4	1210	Risk Ratio (IV, Random, 95% CI)	0.34 [0.13, 0.86]
3 Blood transfusion	4	1030	Risk Ratio (IV, Random, 95% CI)	1.42 [0.42, 4.82]
4 Severe maternal morbidity: intensive care admissions	2	320	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	4	1030	Risk Ratio (IV, Random, 95% CI)	0.96 [0.44, 2.09]
7 Additional uterotonics	6	1530	Risk Ratio (IV, Random, 95% CI)	0.54 [0.30, 1.00]
8 Blood loss	5	1330	Mean Difference (IV, Random, 95% CI)	-44.08 [-82.41, -5.75]
9 Change in haemoglobin	5	1160	Mean Difference (IV, Random, 95% CI)	-2.57 [-4.32, -0.82]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	6	1530	Risk Ratio (IV, Random, 95% CI)	0.29 [0.19, 0.45]
12 Vomiting	6	1530	Risk Ratio (IV, Random, 95% CI)	0.27 [0.16, 0.46]
13 Headache	5	1330	Risk Ratio (IV, Random, 95% CI)	1.41 [0.45, 4.38]
14 Abdominal pain	4	930	Risk Ratio (IV, Random, 95% CI)	0.57 [0.36, 0.91]
15 Hypertension	3	660	Risk Ratio (IV, Random, 95% CI)	0.56 [0.22, 1.39]
16 Shivering	5	1290	Risk Ratio (IV, Random, 95% CI)	0.45 [0.26, 0.80]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 25. Misoprostol plus oxytocin vs Carbetocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	380	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	1	380	Risk Ratio (IV, Random, 95% CI)	4.00 [0.45, 35.46]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	1	380	Risk Ratio (IV, Random, 95% CI)	1.19 [0.74, 1.93]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	1	380	Mean Difference (IV, Random, 95% CI)	-1.70 [-3.72, 0.32]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	380	Risk Ratio (IV, Random, 95% CI)	1.21 [0.62, 2.39]
12 Vomiting	1	380	Risk Ratio (IV, Random, 95% CI)	1.33 [0.58, 3.09]
13 Headache	1	380	Risk Ratio (IV, Random, 95% CI)	2.0 [0.37, 10.79]

14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	1	380	Risk Ratio (IV, Random, 95% CI)	7.83 [3.43, 17.88]
17 Fever	1	380	Risk Ratio (IV, Random, 95% CI)	8.5 [1.99, 36.28]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 26. Ergometrine vs Ergometrine plus oxytocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	144	Risk Ratio (IV, Random, 95% CI)	0.17 [0.01, 4.06]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	1	144	Mean Difference (IV, Random, 95% CI)	20.10 [5.76, 34.44]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 27. Misoprostol plus oxytocin vs Ergometrine

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 28. Misoprostol plus oxytocin vs Ergometrine plus oxytocin

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	1605	Risk Ratio (IV, Random, 95% CI)	1.41 [0.68, 2.94]
3 Blood transfusion	2	1605	Risk Ratio (IV, Random, 95% CI)	0.89 [0.36, 2.19]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	2	1605	Risk Ratio (IV, Random, 95% CI)	1.39 [0.65, 2.99]
7 Additional uterotonics	2	1605	Risk Ratio (IV, Random, 95% CI)	1.48 [0.82, 2.69]
8 Blood loss	1	802	Mean Difference (IV, Random, 95% CI)	-16.0 [-40.24, 8.24]
9 Change in haemoglobin	2	1605	Mean Difference (IV, Random, 95% CI)	-0.50 [-1.72, 0.72]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	2	1605	Risk Ratio (IV, Random, 95% CI)	1.04 [0.23, 4.77]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	2	1605	Risk Ratio (IV, Random, 95% CI)	2.95 [2.02, 4.29]
17 Fever	2	1605	Risk Ratio (IV, Random, 95% CI)	2.89 [1.51, 5.54]
18 Diarrhoea	2	1605	Risk Ratio (IV, Random, 95% CI)	0.81 [0.46, 1.41]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

Comparison 29. Oxytocin vs Placebo or no treatment (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	3	1920	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	3	1920	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	11	8782	Risk Ratio (IV, Random, 95% CI)	0.61 [0.51, 0.72]
2.1 Vaginal birth	10	8731	Risk Ratio (IV, Random, 95% CI)	0.61 [0.51, 0.72]
2.2 Caesarean	1	51	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	8	6717	Risk Ratio (IV, Random, 95% CI)	0.75 [0.51, 1.12]
3.1 Vaginal birth	7	6643	Risk Ratio (IV, Random, 95% CI)	0.75 [0.51, 1.12]
3.2 Caesarean	1	74	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	1	1950	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	1	1950	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	9	7021	Risk Ratio (IV, Random, 95% CI)	0.61 [0.52, 0.71]
6.1 Vaginal birth	8	6970	Risk Ratio (IV, Random, 95% CI)	0.61 [0.52, 0.72]
6.2 Caesarean	1	51	Risk Ratio (IV, Random, 95% CI)	0.48 [0.17, 1.40]
7 Additional uterotonics	8	5047	Risk Ratio (IV, Random, 95% CI)	0.43 [0.32, 0.58]
7.1 Vaginal birth	6	4922	Risk Ratio (IV, Random, 95% CI)	0.49 [0.35, 0.66]
7.2 Caesarean	2	125	Risk Ratio (IV, Random, 95% CI)	0.24 [0.14, 0.44]
8 Blood loss	8	3521	Mean Difference (IV, Random, 95% CI)	-118.52 [-141.40, -95.64]
8.1 Vaginal birth	6	3396	Mean Difference (IV, Random, 95% CI)	-121.22 [-144.50, -97.94]
8.2 Caesarean	2	125	Mean Difference (IV, Random, 95% CI)	-42.70 [-166.12, 80.72]
9 Change in haemoglobin	5	2304	Mean Difference (IV, Random, 95% CI)	-2.68 [-4.47, -0.89]
9.1 Vaginal birth	4	2253	Mean Difference (IV, Random, 95% CI)	-3.19 [-4.98, -1.40]
9.2 Caesarean	1	51	Mean Difference (IV, Random, 95% CI)	-0.20 [-3.51, 3.11]
10 Breastfeeding	1	1540	Risk Ratio (IV, Random, 95% CI)	1.00 [0.95, 1.05]
10.1 Vaginal birth	1	1540	Risk Ratio (IV, Random, 95% CI)	1.00 [0.95, 1.05]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	3	1788	Risk Ratio (IV, Random, 95% CI)	0.82 [0.47, 1.42]
11.1 Vaginal birth	2	1714	Risk Ratio (IV, Random, 95% CI)	0.86 [0.49, 1.51]
11.2 Caesarean	1	74	Risk Ratio (IV, Random, 95% CI)	0.25 [0.02, 3.83]
12 Vomiting	3	2150	Risk Ratio (IV, Random, 95% CI)	1.40 [0.44, 4.41]
12.1 Vaginal birth	2	2076	Risk Ratio (IV, Random, 95% CI)	1.40 [0.44, 4.41]
12.2 Caesarean	1	74	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	2	1704	Risk Ratio (IV, Random, 95% CI)	1.56 [0.52, 4.74]
13.1 Vaginal birth	1	1653	Risk Ratio (IV, Random, 95% CI)	1.26 [0.63, 2.51]
13.2 Caesarean	1	51	Risk Ratio (IV, Random, 95% CI)	6.74 [0.37, 124.21]
14 Abdominal pain	1	1665	Risk Ratio (IV, Random, 95% CI)	0.89 [0.80, 1.00]
14.1 Vaginal birth	1	1665	Risk Ratio (IV, Random, 95% CI)	0.89 [0.80, 1.00]

14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	1	416	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Vaginal birth	1	416	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Ceasarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	1	416	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	1	416	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal sense of well-being	1		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth - Women's perceptions of well-being at 3 months postpartum: Less energy than before birth	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Vaginal birth - Women's perceptions of well-being at 3 months postpartum: Experiencing (some) fatigue	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.3 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	1		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth - Did management influence positively the childbirth experiences of the mothers?	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Vaginal birth - Did management influence negatively the childbirth experiences of the mothers?	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.3 Vaginal birth - Did management make no difference in the childbirth experiences of the mothers?	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.4 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 30. Carbetocin vs Placebo or no treatment (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	50	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Caesarean	1	50	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	50	Risk Ratio (IV, Random, 95% CI)	0.75 [0.30, 1.85]
6.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Caesarean	1	50	Risk Ratio (IV, Random, 95% CI)	0.75 [0.30, 1.85]
7 Additional uterotonics	2	169	Risk Ratio (IV, Random, 95% CI)	0.19 [0.12, 0.32]
7.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Caesarean	2	169	Risk Ratio (IV, Random, 95% CI)	0.19 [0.12, 0.32]
8 Blood loss	1	50	Mean Difference (IV, Random, 95% CI)	-274.0 [-591.60, 43.60]
8.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Caesarean	1	50	Mean Difference (IV, Random, 95% CI)	-274.0 [-591.60, 43.60]
9 Change in haemoglobin	1	50	Mean Difference (IV, Random, 95% CI)	-3.40 [-7.23, 0.43]
9.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Caesarean	1	50	Mean Difference (IV, Random, 95% CI)	-3.40 [-7.23, 0.43]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	1	50	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	1	50	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

19 Maternal well-being	0	Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 31. Misoprostol vs Placebo or no treatment (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	4	3497	Risk Ratio (IV, Random, 95% CI)	1.00 [0.10, 9.59]
1.1 Vaginal birth	4	3497	Risk Ratio (IV, Random, 95% CI)	1.00 [0.10, 9.59]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	8	5467	Risk Ratio (IV, Random, 95% CI)	0.73 [0.56, 0.95]
2.1 Vaginal birth	8	5467	Risk Ratio (IV, Random, 95% CI)	0.73 [0.56, 0.95]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	6	3134	Risk Ratio (IV, Random, 95% CI)	0.46 [0.15, 1.47]
3.1 Vaginal birth	6	3134	Risk Ratio (IV, Random, 95% CI)	0.46 [0.15, 1.47]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	1	1620	Risk Ratio (IV, Random, 95% CI)	1.00 [0.14, 7.05]
4.1 Vaginal birth	1	1620	Risk Ratio (IV, Random, 95% CI)	1.00 [0.14, 7.05]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	7	4047	Risk Ratio (IV, Random, 95% CI)	0.75 [0.59, 0.94]
6.1 Vaginal birth	7	4047	Risk Ratio (IV, Random, 95% CI)	0.75 [0.59, 0.94]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	8	3746	Risk Ratio (IV, Random, 95% CI)	0.67 [0.52, 0.87]
7.1 Vaginal birth	8	3746	Risk Ratio (IV, Random, 95% CI)	0.67 [0.52, 0.87]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	8	4146	Mean Difference (IV, Random, 95% CI)	-42.07 [-52.47, -31.68]
8.1 Vaginal birth	8	4146	Mean Difference (IV, Random, 95% CI)	-42.07 [-52.47, -31.68]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	5	2334	Mean Difference (IV, Random, 95% CI)	-2.53 [-3.53, -1.52]
9.1 Vaginal birth	5	2334	Mean Difference (IV, Random, 95% CI)	-2.53 [-3.53, -1.52]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	4	3997	Risk Ratio (IV, Random, 95% CI)	1.18 [0.78, 1.78]
11.1 Vaginal birth	4	3997	Risk Ratio (IV, Random, 95% CI)	1.18 [0.78, 1.78]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	6	4949	Risk Ratio (IV, Random, 95% CI)	1.41 [0.92, 2.16]

12.1 Vaginal birth	6	4949	Risk Ratio (IV, Random, 95% CI)	1.41 [0.92, 2.16]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	1	1116	Risk Ratio (IV, Random, 95% CI)	0.94 [0.32, 2.77]
13.1 Vaginal birth	1	1116	Risk Ratio (IV, Random, 95% CI)	0.94 [0.32, 2.77]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	4	1894	Risk Ratio (IV, Random, 95% CI)	0.98 [0.29, 3.37]
14.1 Vaginal birth	4	1894	Risk Ratio (IV, Random, 95% CI)	0.98 [0.29, 3.37]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	9	5286	Risk Ratio (IV, Random, 95% CI)	2.94 [2.38, 3.64]
16.1 Vaginal birth	9	5286	Risk Ratio (IV, Random, 95% CI)	2.94 [2.38, 3.64]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	5	4396	Risk Ratio (IV, Random, 95% CI)	4.09 [2.01, 8.32]
17.1 Vaginal birth	5	4396	Risk Ratio (IV, Random, 95% CI)	4.09 [2.01, 8.32]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	6	4791	Risk Ratio (IV, Random, 95% CI)	2.80 [1.21, 6.49]
18.1 Vaginal birth	6	4791	Risk Ratio (IV, Random, 95% CI)	2.80 [1.21, 6.49]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 32. Injectable prostaglandins vs Placebo or no treatment (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	46	Risk Ratio (IV, Random, 95% CI)	0.36 [0.04, 3.24]
2.1 Vaginal birth	1	46	Risk Ratio (IV, Random, 95% CI)	0.36 [0.04, 3.24]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 vaginal birth	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	46	Risk Ratio (IV, Random, 95% CI)	0.55 [0.22, 1.35]

6.1 Vaginal birth	1	46	Risk Ratio (IV, Random, 95% CI)	0.55 [0.22, 1.35]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	2	146	Risk Ratio (IV, Random, 95% CI)	0.66 [0.21, 2.09]
7.1 Vaginal birth	2	146	Risk Ratio (IV, Random, 95% CI)	0.66 [0.21, 2.09]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	2	146	Mean Difference (IV, Random, 95% CI)	-95.17 [-296.09, 105.75]
8.1 Vaginal birth	2	146	Mean Difference (IV, Random, 95% CI)	-95.17 [-296.09, 105.75]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	1	100	Mean Difference (IV, Random, 95% CI)	0.90 [0.56, 1.24]
9.1 Vaginal birth	1	100	Mean Difference (IV, Random, 95% CI)	0.90 [0.56, 1.24]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	46	Risk Ratio (IV, Random, 95% CI)	0.36 [0.02, 8.46]
11.1 Vaginal birth	1	46	Risk Ratio (IV, Random, 95% CI)	0.36 [0.02, 8.46]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 33. Ergometrine vs Placebo or no treatment (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	1429	Risk Ratio (IV, Random, 95% CI)	0.09 [0.01, 0.72]
2.1 Vaginal birth	1	1429	Risk Ratio (IV, Random, 95% CI)	0.09 [0.01, 0.72]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	2	1529	Risk Ratio (IV, Random, 95% CI)	0.34 [0.04, 3.28]
3.1 Vaginal birth	2	1529	Risk Ratio (IV, Random, 95% CI)	0.34 [0.04, 3.28]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	1429	Risk Ratio (IV, Random, 95% CI)	0.24 [0.14, 0.42]
6.1 Vaginal birth	1	1429	Risk Ratio (IV, Random, 95% CI)	0.24 [0.14, 0.42]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	2	1529	Risk Ratio (IV, Random, 95% CI)	0.18 [0.09, 0.37]
7.1 Vaginal birth	2	1529	Risk Ratio (IV, Random, 95% CI)	0.18 [0.09, 0.37]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	2	1529	Mean Difference (IV, Random, 95% CI)	-50.64 [-119.92, 18.65]
8.1 Vaginal birth	2	1529	Mean Difference (IV, Random, 95% CI)	-50.64 [-119.92, 18.65]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	1	100	Mean Difference (IV, Random, 95% CI)	-0.5 [-0.58, -0.42]
9.1 Vaginal birth	1	100	Mean Difference (IV, Random, 95% CI)	-0.5 [-0.58, -0.42]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	1429	Risk Ratio (IV, Random, 95% CI)	42.10 [2.55, 694.80]
11.1 Vaginal birth	1	1429	Risk Ratio (IV, Random, 95% CI)	42.10 [2.55, 694.80]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	1	1429	Risk Ratio (IV, Random, 95% CI)	25.67 [1.52, 432.78]
12.1 Vaginal birth	1	1429	Risk Ratio (IV, Random, 95% CI)	25.67 [1.52, 432.78]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	1	1429	Risk Ratio (IV, Random, 95% CI)	7.19 [0.37, 138.91]
13.1 Vaginal birth	1	1429	Risk Ratio (IV, Random, 95% CI)	7.19 [0.37, 138.91]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	1	1429	Risk Ratio (IV, Random, 95% CI)	2.05 [1.04, 4.08]
14.1 Vaginal birth	1	1429	Risk Ratio (IV, Random, 95% CI)	2.05 [1.04, 4.08]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	1	1429	Risk Ratio (IV, Random, 95% CI)	7.19 [2.83, 18.24]

15.1 Vaginal birth	1	1429	Risk Ratio (IV, Random, 95% CI)	7.19 [2.83, 18.24]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Casarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 34. Ergometrine plus oxytocin vs Placebo or no treatment (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	3207	Risk Ratio (IV, Random, 95% CI)	0.44 [0.18, 1.05]
2.1 Vaginal birth	2	3207	Risk Ratio (IV, Random, 95% CI)	0.44 [0.18, 1.05]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	3	3400	Risk Ratio (IV, Random, 95% CI)	0.34 [0.18, 0.66]
3.1 Vaginal birth	3	3400	Risk Ratio (IV, Random, 95% CI)	0.34 [0.18, 0.66]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	2	3207	Risk Ratio (IV, Random, 95% CI)	0.37 [0.30, 0.46]
6.1 Vaginal birth	2	3207	Risk Ratio (IV, Random, 95% CI)	0.37 [0.30, 0.46]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	3	3400	Risk Ratio (IV, Random, 95% CI)	0.19 [0.15, 0.24]
7.1 Vaginal birth	3	3400	Risk Ratio (IV, Random, 95% CI)	0.19 [0.15, 0.24]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	2	1705	Mean Difference (IV, Random, 95% CI)	-35.02 [-101.63, 31.59]
8.1 Vaginal birth	2	1705	Mean Difference (IV, Random, 95% CI)	-35.02 [-101.63, 31.59]

8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	2	1454	Mean Difference (IV, Random, 95% CI)	-3.57 [-6.50, -0.63]
9.1 Vaginal birth	2	1454	Mean Difference (IV, Random, 95% CI)	-3.57 [-6.50, -0.63]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	2	3207	Risk Ratio (IV, Random, 95% CI)	1.03 [0.99, 1.07]
10.1 Vaginal birth	2	3207	Risk Ratio (IV, Random, 95% CI)	1.03 [0.99, 1.07]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	1512	Risk Ratio (IV, Random, 95% CI)	1.95 [1.38, 2.76]
11.1 Vaginal birth	1	1512	Risk Ratio (IV, Random, 95% CI)	1.95 [1.38, 2.76]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	2	3207	Risk Ratio (IV, Random, 95% CI)	2.15 [1.46, 3.18]
12.1 Vaginal delivery	2	3207	Risk Ratio (IV, Random, 95% CI)	2.15 [1.46, 3.18]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	2	3207	Risk Ratio (IV, Random, 95% CI)	1.65 [0.78, 3.48]
13.1 Vaginal birth	2	3207	Risk Ratio (IV, Random, 95% CI)	1.65 [0.78, 3.48]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	1		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth - General health at 6 weeks postpartum (Worse than prepregnancy)	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Vaginal birth - General health at 6 weeks postpartum (Exhausted since birth)	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.3 Vaginal birth - General health at 6 weeks postpartum (Exhausted at 6 weeks)	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.4 Vaginal birth - General health at 6 weeks postpartum (Blues)	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.5 Vaginal birth - General health at 6 weeks postpartum (Depressed)	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.6 Vaginal birth - General health at 6 weeks postpartum (Help for depression)	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

19.7 Vaginal birth - General health at 6 weeks postpartum (Admission to hospital for depression)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.8 Vaginal birth - General health at 6 weeks postpartum (No health problems reported)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.9 Caesarean	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	1	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth - Satisfied with third-stage management	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Vaginal birth - Felt in control during third stage	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.3 Caesarean	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 35. Misoprostol plus oxytocin vs Placebo or no treatment (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Vaginl birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 36. Misoprostol vs Oxytocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	24	28520	Risk Ratio (IV, Random, 95% CI)	0.62 [0.14, 2.74]
1.1 Vaginal birth	21	27955	Risk Ratio (IV, Random, 95% CI)	0.74 [0.14, 3.95]
1.2 Caesarean	3	565	Risk Ratio (IV, Random, 95% CI)	0.33 [0.01, 8.09]
2 PPH >= 1000 mL	38	34261	Risk Ratio (IV, Random, 95% CI)	1.26 [1.11, 1.43]
2.1 Vaginal birth	31	33496	Risk Ratio (IV, Random, 95% CI)	1.31 [1.15, 1.49]
2.2 Caesarean	7	765	Risk Ratio (IV, Random, 95% CI)	0.83 [0.54, 1.26]
3 Blood transfusion	42	35467	Risk Ratio (IV, Random, 95% CI)	0.81 [0.65, 1.00]
3.1 Vaginal birth	34	34417	Risk Ratio (IV, Random, 95% CI)	0.83 [0.67, 1.03]
3.2 Caesarean	8	1050	Risk Ratio (IV, Random, 95% CI)	0.48 [0.19, 1.21]
4 Severe maternal morbidity: intensive care admissions	10	21698	Risk Ratio (IV, Random, 95% CI)	1.16 [0.55, 2.43]
4.1 Vaginal birth	9	21508	Risk Ratio (IV, Random, 95% CI)	1.16 [0.55, 2.43]

4.2 Caesarean	1	190	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	44	36920	Risk Ratio (IV, Random, 95% CI)	1.08 [0.94, 1.24]
6.1 Vaginal birth	38	36215	Risk Ratio (IV, Random, 95% CI)	1.08 [0.90, 1.31]
6.2 Caesarean	6	705	Risk Ratio (IV, Random, 95% CI)	1.07 [0.92, 1.25]
7 Additional uterotonics	47	35981	Risk Ratio (IV, Random, 95% CI)	1.01 [0.85, 1.20]
7.1 Vaginal birth	35	34521	Risk Ratio (IV, Random, 95% CI)	1.06 [0.86, 1.30]
7.2 Caesarean	12	1460	Risk Ratio (IV, Random, 95% CI)	0.89 [0.69, 1.16]
8 Blood loss	43	35239	Mean Difference (IV, Random, 95% CI)	-8.90 [-23.45, 5.65]
8.1 Vaginal birth	34	34339	Mean Difference (IV, Random, 95% CI)	-2.08 [-16.92, 12.77]
8.2 Caesarean	9	900	Mean Difference (IV, Random, 95% CI)	-59.79 [-89.04, -30.54]
9 Change in haemoglobin	31	12028	Mean Difference (IV, Random, 95% CI)	-0.14 [-0.74, 0.47]
9.1 Vaginal birth	24	11240	Mean Difference (IV, Random, 95% CI)	-0.00 [-0.62, 0.62]
9.2 Caesarean	7	788	Mean Difference (IV, Random, 95% CI)	-0.76 [-2.26, 0.73]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	33	29732	Risk Ratio (IV, Random, 95% CI)	1.22 [0.93, 1.60]
11.1 Vaginal birth	26	28907	Risk Ratio (IV, Random, 95% CI)	1.30 [0.94, 1.79]
11.2 Caesarean	7	825	Risk Ratio (IV, Random, 95% CI)	0.97 [0.61, 1.54]
12 Vomiting	41	32687	Risk Ratio (IV, Random, 95% CI)	1.51 [1.19, 1.91]
12.1 Vaginal birth	30	31402	Risk Ratio (IV, Random, 95% CI)	1.82 [1.43, 2.33]
12.2 Caesarean	11	1285	Risk Ratio (IV, Random, 95% CI)	0.89 [0.55, 1.45]
13 Headache	10	4079	Risk Ratio (IV, Random, 95% CI)	0.88 [0.54, 1.42]
13.1 Vaginal birth	5	3494	Risk Ratio (IV, Random, 95% CI)	1.42 [0.99, 2.04]
13.2 Caesarean	5	585	Risk Ratio (IV, Random, 95% CI)	0.47 [0.19, 1.15]
14 Abdominal pain	8	3382	Risk Ratio (IV, Random, 95% CI)	0.91 [0.79, 1.06]
14.1 Vaginal birth	7	3207	Risk Ratio (IV, Random, 95% CI)	0.87 [0.73, 1.04]
14.2 Caesarean	1	175	Risk Ratio (IV, Random, 95% CI)	1.03 [0.78, 1.37]
15 Hypertension	3	1028	Risk Ratio (IV, Random, 95% CI)	3.64 [0.60, 22.27]
15.1 Vaginal birth	2	828	Risk Ratio (IV, Random, 95% CI)	4.00 [0.44, 36.03]
15.2 Caesarean	1	200	Risk Ratio (IV, Random, 95% CI)	3.0 [0.12, 72.77]
16 Shivering	49	34865	Risk Ratio (IV, Random, 95% CI)	4.02 [3.23, 4.99]
16.1 Vaginal birth	36	33355	Risk Ratio (IV, Random, 95% CI)	4.16 [3.27, 5.29]
16.2 Caesarean	13	1510	Risk Ratio (IV, Random, 95% CI)	3.58 [2.06, 6.21]
17 Fever	41	33008	Risk Ratio (IV, Random, 95% CI)	3.75 [2.73, 5.15]
17.1 Vaginal birth	32	31858	Risk Ratio (IV, Random, 95% CI)	4.62 [3.33, 6.42]
17.2 Caesarean	9	1150	Risk Ratio (IV, Random, 95% CI)	1.52 [0.80, 2.87]
18 Diarrhoea	26	30733	Risk Ratio (IV, Random, 95% CI)	2.13 [1.55, 2.93]
18.1 Vaginal birth	26	30733	Risk Ratio (IV, Random, 95% CI)	2.13 [1.55, 2.93]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	1		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Satisfied or very satisfied with drug	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

20.2 Complaints about or problems with drug	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.3 Would take drug again after subsequent deliveries	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.4 Would recommend drug to a friend	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 37. Injectable prostaglandins vs Oxytocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	200	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	1	200	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	100	Risk Ratio (IV, Random, 95% CI)	1.43 [0.20, 10.31]
2.1 Vaginal birth	2	100	Risk Ratio (IV, Random, 95% CI)	1.43 [0.20, 10.31]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	2	250	Risk Ratio (IV, Random, 95% CI)	1.01 [0.04, 23.65]
3.1 Vaginal birth	2	250	Risk Ratio (IV, Random, 95% CI)	1.01 [0.04, 23.65]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	4	500	Risk Ratio (IV, Random, 95% CI)	0.84 [0.26, 2.71]
6.1 Vaginal birth	4	500	Risk Ratio (IV, Random, 95% CI)	0.84 [0.26, 2.71]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	4	500	Risk Ratio (IV, Random, 95% CI)	0.29 [0.09, 0.94]
7.1 Vaginal birth	4	500	Risk Ratio (IV, Random, 95% CI)	0.29 [0.09, 0.94]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	4	500	Mean Difference (IV, Random, 95% CI)	-15.83 [-152.28, 120.62]
8.1 Vaginal birth	4	500	Mean Difference (IV, Random, 95% CI)	-15.83 [-152.28, 120.62]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	3	450	Risk Ratio (IV, Random, 95% CI)	1.17 [0.40, 3.41]
11.1 Vaginal birth	3	450	Risk Ratio (IV, Random, 95% CI)	1.17 [0.40, 3.41]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	2	400	Risk Ratio (IV, Random, 95% CI)	2.48 [0.57, 10.73]

12.1 Vaginal birth	2	400	Risk Ratio (IV, Random, 95% CI)	2.48 [0.57, 10.73]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	1	200	Risk Ratio (IV, Random, 95% CI)	0.20 [0.01, 4.11]
13.1 Vaginal birth	1	200	Risk Ratio (IV, Random, 95% CI)	0.20 [0.01, 4.11]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	2	400	Risk Ratio (IV, Random, 95% CI)	0.91 [0.11, 7.73]
16.1 Vaginal birth	2	400	Risk Ratio (IV, Random, 95% CI)	0.91 [0.11, 7.73]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	1	200	Risk Ratio (IV, Random, 95% CI)	2.0 [0.18, 21.71]
17.1 Vaginal birth	1	200	Risk Ratio (IV, Random, 95% CI)	2.0 [0.18, 21.71]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	2	400	Risk Ratio (IV, Random, 95% CI)	10.38 [1.96, 54.98]
18.1 Vaginal birth	2	400	Risk Ratio (IV, Random, 95% CI)	10.38 [1.96, 54.98]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 38. Carbetocin vs Oxytocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	5	30327	Risk Ratio (IV, Random, 95% CI)	2.00 [0.37, 10.92]
1.1 Vaginal birth	1	29539	Risk Ratio (IV, Random, 95% CI)	2.00 [0.37, 10.92]
1.2 Caesarean	4	788	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	10	30633	Risk Ratio (IV, Random, 95% CI)	0.73 [0.45, 1.19]
2.1 Vaginal birth	4	29682	Risk Ratio (IV, Random, 95% CI)	0.68 [0.21, 2.20]
2.2 Caesarean	6	951	Risk Ratio (IV, Random, 95% CI)	0.62 [0.31, 1.23]
3 Blood transfusion	16	32115	Risk Ratio (IV, Random, 95% CI)	0.68 [0.38, 1.22]
3.1 Vaginal birth	5	30028	Risk Ratio (IV, Random, 95% CI)	1.04 [0.52, 2.10]
3.2 Caesarean	10	2032	Risk Ratio (IV, Random, 95% CI)	0.50 [0.23, 1.10]
3.3 Both caesarean and vaginal birth	1	55	Risk Ratio (IV, Random, 95% CI)	0.16 [0.01, 2.93]
4 Severe maternal morbidity: intensive care admissions	2	29847	Risk Ratio (IV, Random, 95% CI)	1.16 [0.67, 2.02]
4.1 Vaginal birth	1	29470	Risk Ratio (IV, Random, 95% CI)	1.13 [0.65, 1.98]
4.2 Caesarean	1	377	Risk Ratio (IV, Random, 95% CI)	3.02 [0.12, 73.56]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	11	30633	Risk Ratio (IV, Random, 95% CI)	0.75 [0.58, 0.98]
6.1 Vaginal birth	5	29955	Risk Ratio (IV, Random, 95% CI)	0.67 [0.34, 1.30]
6.2 Caesarean	6	678	Risk Ratio (IV, Random, 95% CI)	0.71 [0.47, 1.07]
7 Additional uterotonics	22	32699	Risk Ratio (IV, Random, 95% CI)	0.48 [0.34, 0.68]
7.1 Vaginal birth	6	30187	Risk Ratio (IV, Random, 95% CI)	0.54 [0.30, 0.99]
7.2 Caesarean	15	2457	Risk Ratio (IV, Random, 95% CI)	0.45 [0.27, 0.74]
7.3 Both caesarean and vaginal birth	1	55	Risk Ratio (IV, Random, 95% CI)	0.37 [0.02, 8.71]
8 Blood loss	16	2115	Mean Difference (IV, Random, 95% CI)	-92.73 [-154.97, -30.49]
8.1 Vaginal birth	4	485	Mean Difference (IV, Random, 95% CI)	-68.42 [-143.52, 6.68]
8.2 Caesarean	12	1630	Mean Difference (IV, Random, 95% CI)	-101.54 [-178.53, -24.55]
9 Change in haemoglobin	12	2096	Mean Difference (IV, Random, 95% CI)	-1.66 [-3.81, 0.50]
9.1 Vaginal birth	3	415	Mean Difference (IV, Random, 95% CI)	-4.21 [-5.34, -3.07]
9.2 Caesarean	8	1626	Mean Difference (IV, Random, 95% CI)	-0.63 [-3.48, 2.22]
9.3 Both caesarean and vaginal birth	1	55	Mean Difference (IV, Random, 95% CI)	-1.70 [-6.97, 3.57]
10 Breastfeeding	2	190	Risk Ratio (IV, Random, 95% CI)	0.94 [0.86, 1.03]
10.1 Vaginal birth	1	135	Risk Ratio (IV, Random, 95% CI)	0.93 [0.85, 1.03]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.3 Both caesarean and vaginal birth	1	55	Risk Ratio (IV, Random, 95% CI)	0.98 [0.79, 1.22]
11 Nausea	12	2288	Risk Ratio (IV, Random, 95% CI)	1.11 [0.78, 1.56]
11.1 Vaginal birth	4	555	Risk Ratio (IV, Random, 95% CI)	1.30 [0.37, 4.60]
11.2 Caesarean	8	1733	Risk Ratio (IV, Random, 95% CI)	1.10 [0.75, 1.61]
12 Vomiting	13	31833	Risk Ratio (IV, Random, 95% CI)	0.90 [0.53, 1.50]
12.1 Vaginal birth	5	30055	Risk Ratio (IV, Random, 95% CI)	0.85 [0.14, 5.25]
12.2 Caesarean	7	1723	Risk Ratio (IV, Random, 95% CI)	0.83 [0.44, 1.60]
12.3 Both caesarean and vaginal birth	1	55	Risk Ratio (IV, Random, 95% CI)	3.33 [0.14, 78.42]
13 Headache	15	2620	Risk Ratio (IV, Random, 95% CI)	0.84 [0.63, 1.12]
13.1 Vaginal birth	4	555	Risk Ratio (IV, Random, 95% CI)	1.15 [0.41, 3.26]
13.2 Caesarean	10	2010	Risk Ratio (IV, Random, 95% CI)	0.81 [0.61, 1.08]
13.3 Both caesarean and vaginal birth	1	55	Risk Ratio (IV, Random, 95% CI)	7.78 [0.42, 143.81]
14 Abdominal pain	10	31293	Risk Ratio (IV, Random, 95% CI)	1.18 [0.97, 1.44]
14.1 Vaginal birth	5	29946	Risk Ratio (IV, Random, 95% CI)	1.09 [0.79, 1.49]
14.2 Caesarean	5	1347	Risk Ratio (IV, Random, 95% CI)	1.21 [0.90, 1.62]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	9	1998	Risk Ratio (IV, Random, 95% CI)	0.78 [0.49, 1.23]
16.1 Vaginal birth	3	495	Risk Ratio (IV, Random, 95% CI)	1.22 [0.49, 3.07]
16.2 Caesarean	6	1503	Risk Ratio (IV, Random, 95% CI)	0.70 [0.40, 1.20]
17 Fever	4	466	Risk Ratio (IV, Random, 95% CI)	1.58 [0.27, 9.35]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	3	411	Risk Ratio (IV, Random, 95% CI)	2.90 [0.19, 43.87]
17.3 Both caesarean and vaginal birth	1	55	Risk Ratio (IV, Random, 95% CI)	0.37 [0.02, 8.71]

18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 39. Ergometrine vs Oxytocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	1293	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	1	1293	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	6	2591	Risk Ratio (IV, Random, 95% CI)	1.30 [0.52, 3.27]
2.1 Vaginal birth	6	2591	Risk Ratio (IV, Random, 95% CI)	1.30 [0.52, 3.27]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	5	1893	Risk Ratio (IV, Random, 95% CI)	1.44 [0.20, 10.23]
3.1 Vaginal birth	5	1893	Risk Ratio (IV, Random, 95% CI)	1.44 [0.20, 10.23]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	10	3221	Risk Ratio (IV, Random, 95% CI)	1.31 [0.86, 1.99]
6.1 Vaginal birth	10	3221	Risk Ratio (IV, Random, 95% CI)	1.31 [0.86, 1.99]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	6	2493	Risk Ratio (IV, Random, 95% CI)	1.46 [0.61, 3.48]
7.1 Vaginal birth	6	2493	Risk Ratio (IV, Random, 95% CI)	1.46 [0.61, 3.48]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	10	3221	Mean Difference (IV, Random, 95% CI)	8.09 [-17.83, 34.00]
8.1 Vaginal birth	10	3221	Mean Difference (IV, Random, 95% CI)	8.09 [-17.83, 34.00]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	2	1893	Mean Difference (IV, Random, 95% CI)	0.42 [-0.30, 1.13]
9.1 Vaginal birth	2	1893	Mean Difference (IV, Random, 95% CI)	0.42 [-0.30, 1.13]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	6	2529	Risk Ratio (IV, Random, 95% CI)	4.56 [1.13, 18.44]
11.1 Vaginal birth	6	2529	Risk Ratio (IV, Random, 95% CI)	4.56 [1.13, 18.44]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

12 Vomiting	5	2343	Risk Ratio (IV, Random, 95% CI)	3.83 [1.10, 13.28]
12.1 Vaginal birth	5	2343	Risk Ratio (IV, Random, 95% CI)	3.83 [1.10, 13.28]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	4	2293	Risk Ratio (IV, Random, 95% CI)	5.63 [0.93, 33.96]
13.1 Vaginal birth	4	2293	Risk Ratio (IV, Random, 95% CI)	5.63 [0.93, 33.96]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	3	1410	Risk Ratio (IV, Random, 95% CI)	13.39 [2.01, 89.44]
15.1 Vaginal birth	3	1410	Risk Ratio (IV, Random, 95% CI)	13.39 [2.01, 89.44]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	3	1493	Risk Ratio (IV, Random, 95% CI)	1.73 [0.93, 3.25]
16.1 Vaginal birth	3	1493	Risk Ratio (IV, Random, 95% CI)	1.73 [0.93, 3.25]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	2	1443	Risk Ratio (IV, Random, 95% CI)	2.97 [0.97, 9.05]
17.1 Vaginal birth	2	1443	Risk Ratio (IV, Random, 95% CI)	2.97 [0.97, 9.05]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	2	1393	Risk Ratio (IV, Random, 95% CI)	3.74 [0.42, 33.53]
18.1 Vaginal birth	2	1393	Risk Ratio (IV, Random, 95% CI)	3.74 [0.42, 33.53]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 40. Ergometine plus oxytocin vs Oxytocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	2	1314	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	2	1314	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	10	10990	Risk Ratio (IV, Random, 95% CI)	0.73 [0.57, 0.93]
2.1 Vaginal birth	10	10990	Risk Ratio (IV, Random, 95% CI)	0.73 [0.57, 0.93]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	11	10985	Risk Ratio (IV, Random, 95% CI)	0.88 [0.53, 1.44]
3.1 Vaginal birth	9	10521	Risk Ratio (IV, Random, 95% CI)	1.00 [0.61, 1.64]
3.2 Caesarean	2	464	Risk Ratio (IV, Random, 95% CI)	0.39 [0.17, 0.91]
4 Severe maternal morbidity: intensive care admissions	1	991	Risk Ratio (IV, Random, 95% CI)	2.99 [0.12, 73.32]
4.1 Vaginal birth	1	991	Risk Ratio (IV, Random, 95% CI)	2.99 [0.12, 73.32]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

6 PPH >= 500 mL	11	11090	Risk Ratio (IV, Random, 95% CI)	0.72 [0.57, 0.91]
6.1 Vaginal birth	11	11090	Risk Ratio (IV, Random, 95% CI)	0.72 [0.57, 0.91]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	10	8968	Risk Ratio (IV, Random, 95% CI)	0.79 [0.59, 1.07]
7.1 Vaginal birth	8	8504	Risk Ratio (IV, Random, 95% CI)	0.80 [0.58, 1.10]
7.2 Caesarean	2	464	Risk Ratio (IV, Random, 95% CI)	0.74 [0.22, 2.48]
8 Blood loss	10	4248	Mean Difference (IV, Random, 95% CI)	-10.31 [-40.32, 19.70]
8.1 Vaginal birth	7	3729	Mean Difference (IV, Random, 95% CI)	-0.12 [-33.85, 33.60]
8.2 Caesarean	3	519	Mean Difference (IV, Random, 95% CI)	-49.54 [-88.07, -11.01]
9 Change in haemoglobin	6	4324	Mean Difference (IV, Random, 95% CI)	-2.23 [-5.24, 0.77]
9.1 Vaginal birth	6	4324	Mean Difference (IV, Random, 95% CI)	-2.23 [-5.24, 0.77]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	1	3483	Risk Ratio (IV, Random, 95% CI)	0.99 [0.96, 1.01]
10.1 Vaginal birth	1	3483	Risk Ratio (IV, Random, 95% CI)	0.99 [0.96, 1.01]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	7	6931	Risk Ratio (IV, Random, 95% CI)	1.72 [0.84, 3.53]
11.1 Vaginal birth	5	6467	Risk Ratio (IV, Random, 95% CI)	1.58 [0.65, 3.86]
11.2 Caesarean	2	464	Risk Ratio (IV, Random, 95% CI)	2.09 [0.53, 8.22]
12 Vomiting	9	10227	Risk Ratio (IV, Random, 95% CI)	3.05 [1.76, 5.29]
12.1 Vaginal birth	7	9763	Risk Ratio (IV, Random, 95% CI)	2.93 [1.50, 5.71]
12.2 Caesarean	2	464	Risk Ratio (IV, Random, 95% CI)	2.83 [1.12, 7.15]
13 Headache	5	5105	Risk Ratio (IV, Random, 95% CI)	1.26 [0.79, 1.99]
13.1 Vaginal birth	4	4689	Risk Ratio (IV, Random, 95% CI)	1.74 [0.67, 4.55]
13.2 Caesarean	1	416	Risk Ratio (IV, Random, 95% CI)	1.06 [0.59, 1.91]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	3	1362	Risk Ratio (IV, Random, 95% CI)	2.00 [0.29, 13.97]
15.1 Vaginal birth	2	1314	Risk Ratio (IV, Random, 95% CI)	4.57 [0.65, 32.04]
15.2 Caesarean	1	48	Risk Ratio (IV, Random, 95% CI)	0.25 [0.03, 2.08]
16 Shivering	2	1591	Risk Ratio (IV, Random, 95% CI)	0.96 [0.60, 1.53]
16.1 Vaginal birth	2	1591	Risk Ratio (IV, Random, 95% CI)	0.96 [0.60, 1.53]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	2	1591	Risk Ratio (IV, Random, 95% CI)	1.08 [0.48, 2.43]
17.1 Vaginal birth	2	1591	Risk Ratio (IV, Random, 95% CI)	1.08 [0.48, 2.43]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	3	2030	Risk Ratio (IV, Random, 95% CI)	1.26 [0.72, 2.22]
18.1 Vaginal birth	3	2030	Risk Ratio (IV, Random, 95% CI)	1.26 [0.72, 2.22]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 41. Misoprostol plus oxytocin vs Oxytocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	9	4737	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	5	3802	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	4	935	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	17	8514	Risk Ratio (IV, Random, 95% CI)	0.87 [0.69, 1.09]
2.1 Vaginal birth	7	6241	Risk Ratio (IV, Random, 95% CI)	0.77 [0.52, 1.14]
2.2 Caesarean	10	2273	Risk Ratio (IV, Random, 95% CI)	0.93 [0.70, 1.24]
3 Blood transfusion	19	8742	Risk Ratio (IV, Random, 95% CI)	0.50 [0.37, 0.67]
3.1 Vaginal birth	7	5898	Risk Ratio (IV, Random, 95% CI)	0.39 [0.25, 0.61]
3.2 Caesarean	12	2844	Risk Ratio (IV, Random, 95% CI)	0.59 [0.36, 0.96]
4 Severe maternal morbidity: intensive care admissions	3	1886	Risk Ratio (IV, Random, 95% CI)	0.50 [0.05, 5.47]
4.1 Vaginal birth	1	1400	Risk Ratio (IV, Random, 95% CI)	0.50 [0.05, 5.47]
4.2 Caesarean	2	486	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	14	8148	Risk Ratio (IV, Random, 95% CI)	0.71 [0.59, 0.85]
6.1 Vaginal birth	8	6997	Risk Ratio (IV, Random, 95% CI)	0.71 [0.55, 0.92]
6.2 Caesarean	6	1151	Risk Ratio (IV, Random, 95% CI)	0.69 [0.51, 0.92]
7 Additional uterotonics	18	8391	Risk Ratio (IV, Random, 95% CI)	0.54 [0.44, 0.67]
7.1 Vaginal birth	7	5898	Risk Ratio (IV, Random, 95% CI)	0.63 [0.49, 0.79]
7.2 Caesarean	11	2493	Risk Ratio (IV, Random, 95% CI)	0.49 [0.36, 0.66]
8 Blood loss	17	8690	Mean Difference (IV, Random, 95% CI)	-87.26 [-157.83, -16.69]
8.1 Vaginal birth	7	6179	Mean Difference (IV, Random, 95% CI)	-12.23 [-26.51, 2.06]
8.2 Caesarean	10	2511	Mean Difference (IV, Random, 95% CI)	-134.79 [-276.45, 6.88]
9 Change in haemoglobin	15	7929	Mean Difference (IV, Random, 95% CI)	-2.59 [-3.70, -1.48]
9.1 Vaginal birth	6	5643	Mean Difference (IV, Random, 95% CI)	-0.89 [-1.61, -0.17]
9.2 Caesarean	9	2286	Mean Difference (IV, Random, 95% CI)	-2.00 [-5.60, -2.39]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	7	3798	Risk Ratio (IV, Random, 95% CI)	2.21 [1.19, 4.10]
11.1 Vaginal birth	2	3003	Risk Ratio (IV, Random, 95% CI)	3.52 [1.55, 7.99]
11.2 Caesarean	5	795	Risk Ratio (IV, Random, 95% CI)	1.71 [0.76, 3.84]
12 Vomiting	11	6718	Risk Ratio (IV, Random, 95% CI)	2.24 [1.52, 3.31]
12.1 Vaginal birth	6	5610	Risk Ratio (IV, Random, 95% CI)	3.32 [2.03, 5.44]
12.2 Caesarean	5	1108	Risk Ratio (IV, Random, 95% CI)	1.51 [0.96, 2.36]
13 Headache	2	303	Risk Ratio (IV, Random, 95% CI)	1.26 [0.26, 6.23]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	2	303	Risk Ratio (IV, Random, 95% CI)	1.26 [0.26, 6.23]
14 Abdominal pain	1	366	Risk Ratio (IV, Random, 95% CI)	1.93 [1.01, 3.67]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

14.2 Caesarean	1	366	Risk Ratio (IV, Random, 95% CI)	1.93 [1.01, 3.67]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	19	9458	Risk Ratio (IV, Random, 95% CI)	3.38 [2.50, 4.57]
16.1 Vaginal birth	8	7007	Risk Ratio (IV, Random, 95% CI)	3.68 [2.41, 5.60]
16.2 Caesarean	11	2451	Risk Ratio (IV, Random, 95% CI)	3.04 [2.00, 4.61]
17 Fever	17	8607	Risk Ratio (IV, Random, 95% CI)	2.99 [2.00, 4.45]
17.1 Vaginal birth	7	6209	Risk Ratio (IV, Random, 95% CI)	4.30 [2.57, 7.21]
17.2 Caesarean	10	2398	Risk Ratio (IV, Random, 95% CI)	1.85 [1.28, 2.67]
18 Diarrhoea	7	5649	Risk Ratio (IV, Random, 95% CI)	2.08 [0.99, 4.38]
18.1 Vaginal birth	5	4887	Risk Ratio (IV, Random, 95% CI)	1.89 [0.82, 4.36]
18.2 Caesarean	2	762	Risk Ratio (IV, Random, 95% CI)	6.07 [0.73, 50.35]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 42. Injectable prostaglandins vs Misoprostol (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	170	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
2.1 Vaginal birth	2	170	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	4	403	Risk Ratio (IV, Random, 95% CI)	0.88 [0.14, 5.39]
3.1 Vaginal birth	4	403	Risk Ratio (IV, Random, 95% CI)	0.88 [0.14, 5.39]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	3	303	Risk Ratio (IV, Random, 95% CI)	1.60 [0.57, 4.52]
6.1 Vaginal birth	3	303	Risk Ratio (IV, Random, 95% CI)	1.60 [0.57, 4.52]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	4	403	Risk Ratio (IV, Random, 95% CI)	1.02 [0.28, 3.69]
7.1 Vaginal birth	4	403	Risk Ratio (IV, Random, 95% CI)	1.02 [0.28, 3.69]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	3	270	Mean Difference (IV, Random, 95% CI)	52.99 [-39.74, 145.71]

8.1 Vaginal birth	3	270	Mean Difference (IV, Random, 95% CI)	52.99 [-39.74, 145.71]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	2	220	Mean Difference (IV, Random, 95% CI)	2.28 [-1.35, 5.90]
9.1 Vaginal birth	2	220	Mean Difference (IV, Random, 95% CI)	2.28 [-1.35, 5.90]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	2	233	Risk Ratio (IV, Random, 95% CI)	0.23 [0.06, 0.92]
11.1 Vaginal birth	2	233	Risk Ratio (IV, Random, 95% CI)	0.23 [0.06, 0.92]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	2	233	Risk Ratio (IV, Random, 95% CI)	1.31 [0.01, 163.15]
12.1 Vaginal birth	2	233	Risk Ratio (IV, Random, 95% CI)	1.31 [0.01, 163.15]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	2	233	Risk Ratio (IV, Random, 95% CI)	0.99 [0.20, 4.80]
14.1 Vaginal birth	2	233	Risk Ratio (IV, Random, 95% CI)	0.99 [0.20, 4.80]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	3	353	Risk Ratio (IV, Random, 95% CI)	0.04 [0.01, 0.21]
16.1 Vaginal birth	3	353	Risk Ratio (IV, Random, 95% CI)	0.04 [0.01, 0.21]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	2	233	Risk Ratio (IV, Random, 95% CI)	0.08 [0.01, 0.39]
17.1 Vaginal birth	2	233	Risk Ratio (IV, Random, 95% CI)	0.08 [0.01, 0.39]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	2	233	Risk Ratio (IV, Random, 95% CI)	9.03 [1.70, 48.00]
18.1 Vaginal birth	2	233	Risk Ratio (IV, Random, 95% CI)	9.03 [1.70, 48.00]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 43. Misoprostol vs Carbetocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	177	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	1	177	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	177	Risk Ratio (IV, Random, 95% CI)	2.31 [0.62, 8.64]
2.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

2.2 Caesarean	1	177	Risk Ratio (IV, Random, 95% CI)	2.31 [0.62, 8.64]
3 Blood transfusion	1	177	Risk Ratio (IV, Random, 95% CI)	2.97 [0.12, 71.85]
3.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Caesarean	1	177	Risk Ratio (IV, Random, 95% CI)	2.97 [0.12, 71.85]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	177	Risk Ratio (IV, Random, 95% CI)	2.31 [1.52, 3.50]
6.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Caesarean	1	177	Risk Ratio (IV, Random, 95% CI)	2.31 [1.52, 3.50]
7 Additional uterotonics	1	177	Risk Ratio (IV, Random, 95% CI)	3.96 [1.55, 10.07]
7.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Caesarean	1	177	Risk Ratio (IV, Random, 95% CI)	3.96 [1.55, 10.07]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	177	Risk Ratio (IV, Random, 95% CI)	0.99 [0.47, 2.08]
11.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Caesarean	1	177	Risk Ratio (IV, Random, 95% CI)	0.99 [0.47, 2.08]
12 Vomiting	1	177	Risk Ratio (IV, Random, 95% CI)	1.48 [0.55, 3.99]
12.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Caesarean	1	177	Risk Ratio (IV, Random, 95% CI)	1.48 [0.55, 3.99]
13 Headache	1	177	Risk Ratio (IV, Random, 95% CI)	1.19 [0.71, 1.99]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	1	177	Risk Ratio (IV, Random, 95% CI)	1.19 [0.71, 1.99]
14 Abdominal pain	1	177	Risk Ratio (IV, Random, 95% CI)	0.65 [0.52, 0.80]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	1	177	Risk Ratio (IV, Random, 95% CI)	0.65 [0.52, 0.80]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	1	177	Risk Ratio (IV, Random, 95% CI)	3.46 [1.67, 7.17]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	1	177	Risk Ratio (IV, Random, 95% CI)	3.46 [1.67, 7.17]
17 Fever	1	177	Risk Ratio (IV, Random, 95% CI)	2.55 [1.41, 4.64]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	1	177	Risk Ratio (IV, Random, 95% CI)	2.55 [1.41, 4.64]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

19.1 Vaginal birth	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 44. Ergometrine vs Misoprostol (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	7	5254	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	7	5254	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	11	5562	Risk Ratio (IV, Random, 95% CI)	1.25 [0.45, 3.48]
2.1 Vaginal birth	11	5562	Risk Ratio (IV, Random, 95% CI)	1.25 [0.45, 3.48]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	13	5308	Risk Ratio (IV, Random, 95% CI)	1.71 [0.65, 4.50]
3.1 Vaginal birth	13	5308	Risk Ratio (IV, Random, 95% CI)	1.71 [0.65, 4.50]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	1	864	Risk Ratio (IV, Random, 95% CI)	0.33 [0.01, 8.16]
4.1 Vaginal birth	1	864	Risk Ratio (IV, Random, 95% CI)	0.33 [0.01, 8.16]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	16	6459	Risk Ratio (IV, Random, 95% CI)	1.18 [0.79, 1.75]
6.1 Vaginal birth	16	6459	Risk Ratio (IV, Random, 95% CI)	1.18 [0.79, 1.75]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	16	6565	Risk Ratio (IV, Random, 95% CI)	1.04 [0.68, 1.60]
7.1 Vaginal birth	16	6565	Risk Ratio (IV, Random, 95% CI)	1.04 [0.68, 1.60]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	15	6337	Mean Difference (IV, Random, 95% CI)	11.66 [-9.85, 33.17]
8.1 Vaginal birth	15	6337	Mean Difference (IV, Random, 95% CI)	11.66 [-9.85, 33.17]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	8	4438	Mean Difference (IV, Random, 95% CI)	0.91 [-0.43, 2.26]
9.1 Vaginal birth	8	4438	Mean Difference (IV, Random, 95% CI)	0.91 [-0.43, 2.26]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	13	5202	Risk Ratio (IV, Random, 95% CI)	1.53 [1.15, 2.04]
11.1 Vaginal birth	13	5202	Risk Ratio (IV, Random, 95% CI)	1.53 [1.15, 2.04]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	14	6136	Risk Ratio (IV, Random, 95% CI)	1.22 [0.81, 1.83]
12.1 Vaginal birth	14	6136	Risk Ratio (IV, Random, 95% CI)	1.22 [0.81, 1.83]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	8	3369	Risk Ratio (IV, Random, 95% CI)	1.70 [0.70, 4.12]

13.1 Vaginal birth	8	3369	Risk Ratio (IV, Random, 95% CI)	1.70 [0.70, 4.12]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	2	233	Risk Ratio (IV, Random, 95% CI)	1.58 [0.04, 65.80]
14.1 Vaginal birth	2	233	Risk Ratio (IV, Random, 95% CI)	1.58 [0.04, 65.80]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	2	300	Risk Ratio (IV, Random, 95% CI)	7.55 [0.94, 60.53]
15.1 Vaginal birth	2	300	Risk Ratio (IV, Random, 95% CI)	7.55 [0.94, 60.53]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	17	6860	Risk Ratio (IV, Random, 95% CI)	0.34 [0.26, 0.44]
16.1 Vaginal birth	17	6860	Risk Ratio (IV, Random, 95% CI)	0.34 [0.26, 0.44]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	14	6330	Risk Ratio (IV, Random, 95% CI)	0.24 [0.17, 0.33]
17.1 Vaginal birth	14	6330	Risk Ratio (IV, Random, 95% CI)	0.24 [0.17, 0.33]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	8	4165	Risk Ratio (IV, Random, 95% CI)	1.04 [0.46, 2.34]
18.1 Vaginal birth	8	4165	Risk Ratio (IV, Random, 95% CI)	1.04 [0.46, 2.34]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 45. Misoprostol vs Ergometrine plus oxytocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	4	3258	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	4	3258	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	9	6028	Risk Ratio (IV, Random, 95% CI)	1.61 [1.08, 2.40]
2.1 Vaginal birth	9	6028	Risk Ratio (IV, Random, 95% CI)	1.61 [1.08, 2.40]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	8	6335	Risk Ratio (IV, Random, 95% CI)	1.41 [0.91, 2.21]
3.1 Vaginal birth	8	6335	Risk Ratio (IV, Random, 95% CI)	1.41 [0.91, 2.21]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	10	6492	Risk Ratio (IV, Random, 95% CI)	1.75 [1.35, 2.26]
6.1 Vaginal birth	10	6492	Risk Ratio (IV, Random, 95% CI)	1.75 [1.35, 2.26]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	9	6395	Risk Ratio (IV, Random, 95% CI)	1.87 [1.49, 2.36]

7.1 Vaginal birth	9	6395	Risk Ratio (IV, Random, 95% CI)	1.87 [1.49, 2.36]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	8	5634	Mean Difference (IV, Random, 95% CI)	22.86 [4.50, 41.22]
8.1 Vaginal birth	8	5634	Mean Difference (IV, Random, 95% CI)	22.86 [4.50, 41.22]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	9	5588	Mean Difference (IV, Random, 95% CI)	1.09 [-0.49, 2.67]
9.1 Vaginal birth	9	5588	Mean Difference (IV, Random, 95% CI)	1.09 [-0.49, 2.67]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	4	3399	Risk Ratio (IV, Random, 95% CI)	0.71 [0.61, 0.84]
11.1 Vaginal birth	4	3399	Risk Ratio (IV, Random, 95% CI)	0.71 [0.61, 0.84]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	6	4983	Risk Ratio (IV, Random, 95% CI)	0.72 [0.50, 1.04]
12.1 Vaginal birth	6	4983	Risk Ratio (IV, Random, 95% CI)	0.72 [0.50, 1.04]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	3	3259	Risk Ratio (IV, Random, 95% CI)	0.91 [0.47, 1.76]
13.1 Vaginal birth	3	3259	Risk Ratio (IV, Random, 95% CI)	0.91 [0.47, 1.76]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	1	846	Risk Ratio (IV, Random, 95% CI)	0.90 [0.79, 1.02]
14.1 Vaginal birth	1	846	Risk Ratio (IV, Random, 95% CI)	0.90 [0.79, 1.02]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	3	2553	Risk Ratio (IV, Random, 95% CI)	0.50 [0.18, 1.41]
15.1 Vaginal birth	3	2553	Risk Ratio (IV, Random, 95% CI)	0.50 [0.18, 1.41]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	6	4980	Risk Ratio (IV, Random, 95% CI)	2.71 [1.95, 3.76]
16.1 Vaginal birth	6	4980	Risk Ratio (IV, Random, 95% CI)	2.71 [1.95, 3.76]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	7	5045	Risk Ratio (IV, Random, 95% CI)	5.33 [2.87, 9.88]
17.1 Vaginal birth	7	5045	Risk Ratio (IV, Random, 95% CI)	5.33 [2.87, 9.88]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	6	3659	Risk Ratio (IV, Random, 95% CI)	1.04 [0.68, 1.57]
18.1 Vaginal birth	6	3659	Risk Ratio (IV, Random, 95% CI)	1.04 [0.68, 1.57]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	1		Mean Difference (IV, Fixed, 95% CI)	Totals not selected
20.1 Vaginal birth	1		Mean Difference (IV, Fixed, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Mean Difference (IV, Fixed, 95% CI)	0.0 [0.0, 0.0]

Comparison 46. Misoprostol vs Misoprostol plus oxytocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	1589	Risk Ratio (IV, Random, 95% CI)	1.85 [1.03, 3.33]
2.1 Vaginal birth	2	1589	Risk Ratio (IV, Random, 95% CI)	1.85 [1.03, 3.33]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	2	1589	Risk Ratio (IV, Random, 95% CI)	2.97 [1.40, 6.30]
3.1 Vaginal birth	2	1589	Risk Ratio (IV, Random, 95% CI)	2.97 [1.40, 6.30]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity:shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	2	1589	Risk Ratio (IV, Random, 95% CI)	1.93 [0.99, 3.76]
6.1 Vaginal birth	2	1589	Risk Ratio (IV, Random, 95% CI)	1.93 [0.99, 3.76]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	3	1689	Risk Ratio (IV, Random, 95% CI)	1.89 [1.26, 2.83]
7.1 Vaginal birth	2	1589	Risk Ratio (IV, Random, 95% CI)	2.12 [1.35, 3.32]
7.2 Caesarean	1	100	Risk Ratio (IV, Random, 95% CI)	1.14 [0.45, 2.91]
8 Blood loss	1	792	Mean Difference (IV, Random, 95% CI)	48.0 [24.68, 71.32]
8.1 Vaginal birth	1	792	Mean Difference (IV, Random, 95% CI)	48.0 [24.68, 71.32]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	3	1689	Mean Difference (IV, Random, 95% CI)	0.27 [-0.42, 0.96]
9.1 Vaginal birth	2	1589	Mean Difference (IV, Random, 95% CI)	0.0 [-1.21, 1.21]
9.2 Caesarean	1	100	Mean Difference (IV, Random, 95% CI)	0.40 [-0.43, 1.23]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	100	Risk Ratio (IV, Random, 95% CI)	1.83 [0.73, 4.57]
11.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Caesarean	1	100	Risk Ratio (IV, Random, 95% CI)	1.83 [0.73, 4.57]
12 Vomiting	3	1689	Risk Ratio (IV, Random, 95% CI)	1.39 [0.51, 3.82]
12.1 Vaginal birth	2	1589	Risk Ratio (IV, Random, 95% CI)	1.03 [0.33, 3.24]
12.2 Caesarean	1	100	Risk Ratio (IV, Random, 95% CI)	4.0 [0.46, 34.54]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	3	1689	Risk Ratio (IV, Random, 95% CI)	0.94 [0.72, 1.22]

16.1 Vaginal birth	2	1589	Risk Ratio (IV, Random, 95% CI)	0.92 [0.71, 1.21]
16.2 Caesarean	1	100	Risk Ratio (IV, Random, 95% CI)	7.0 [0.37, 132.10]
17 Fever	3	1689	Risk Ratio (IV, Random, 95% CI)	0.97 [0.62, 1.53]
17.1 Vaginal birth	2	1589	Risk Ratio (IV, Random, 95% CI)	0.97 [0.61, 1.54]
17.2 Caesarean	1	100	Risk Ratio (IV, Random, 95% CI)	1.0 [0.15, 6.82]
18 Diarrhoea	2	1589	Risk Ratio (IV, Random, 95% CI)	1.22 [0.70, 2.13]
18.1 Vaginal birth	2	1589	Risk Ratio (IV, Random, 95% CI)	1.22 [0.70, 2.13]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 47. Carbetocin vs Injectable prostaglandins (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 48. Injectable prostaglandins vs Ergometrine (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	50	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
2.1 Vaginal birth	1	50	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	4	384	Risk Ratio (IV, Random, 95% CI)	1.01 [0.04, 23.58]
3.1 Vaginal birth	4	384	Risk Ratio (IV, Random, 95% CI)	1.01 [0.04, 23.58]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	3	399	Risk Ratio (IV, Random, 95% CI)	1.42 [0.64, 3.17]
6.1 Vaginal birth	3	399	Risk Ratio (IV, Random, 95% CI)	1.42 [0.64, 3.17]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	5	684	Risk Ratio (IV, Random, 95% CI)	0.78 [0.40, 1.51]
7.1 Vaginal birth	5	684	Risk Ratio (IV, Random, 95% CI)	0.78 [0.40, 1.51]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	8	1195	Mean Difference (IV, Random, 95% CI)	-16.08 [-57.17, 25.00]
8.1 Vaginal birth	8	1195	Mean Difference (IV, Random, 95% CI)	-16.08 [-57.17, 25.00]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	2	300	Mean Difference (IV, Random, 95% CI)	-1.28 [-6.58, 4.01]
9.1 Vaginal birth	2	300	Mean Difference (IV, Random, 95% CI)	-1.28 [-6.58, 4.01]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	5	684	Risk Ratio (IV, Random, 95% CI)	1.70 [0.98, 2.94]
11.1 Vaginal birth	5	684	Risk Ratio (IV, Random, 95% CI)	1.70 [0.98, 2.94]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	5	684	Risk Ratio (IV, Random, 95% CI)	2.70 [0.97, 7.55]
12.1 Vaginal birth	5	684	Risk Ratio (IV, Random, 95% CI)	2.70 [0.97, 7.55]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	1	80	Risk Ratio (IV, Random, 95% CI)	2.0 [0.39, 10.31]
13.1 Vaginal birth	1	80	Risk Ratio (IV, Random, 95% CI)	2.0 [0.39, 10.31]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	3	384	Risk Ratio (IV, Random, 95% CI)	1.70 [0.07, 40.44]
14.1 Vaginal birth	3	384	Risk Ratio (IV, Random, 95% CI)	1.70 [0.07, 40.44]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	2	315	Risk Ratio (IV, Random, 95% CI)	0.16 [0.02, 1.37]
15.1 Vaginal birth	2	315	Risk Ratio (IV, Random, 95% CI)	0.16 [0.02, 1.37]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	3	434	Risk Ratio (IV, Random, 95% CI)	0.38 [0.16, 0.91]
16.1 Vaginal birth	3	434	Risk Ratio (IV, Random, 95% CI)	0.38 [0.16, 0.91]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	4	534	Risk Ratio (IV, Random, 95% CI)	4.52 [0.76, 26.80]
17.1 Vaginal birth	4	534	Risk Ratio (IV, Random, 95% CI)	4.52 [0.76, 26.80]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	5	664	Risk Ratio (IV, Random, 95% CI)	10.09 [2.75, 37.00]
18.1 Vaginal birth	5	664	Risk Ratio (IV, Random, 95% CI)	10.09 [2.75, 37.00]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 49. Injectable prostaglandins vs Ergometrine plus oxytocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	598	Risk Ratio (IV, Random, 95% CI)	0.80 [0.17, 3.78]
2.1 Vaginal birth	1	69	Risk Ratio (IV, Random, 95% CI)	0.36 [0.11, 1.23]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.3 Both caesarean and vaginal birth	1	529	Risk Ratio (IV, Random, 95% CI)	1.77 [0.52, 5.97]
3 Blood transfusion	1	69	Risk Ratio (IV, Random, 95% CI)	0.65 [0.17, 2.53]
3.1 Vaginal birth	1	69	Risk Ratio (IV, Random, 95% CI)	0.65 [0.17, 2.53]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	2	598	Risk Ratio (IV, Random, 95% CI)	1.29 [0.92, 1.79]
6.1 Vaginal birth	1	69	Risk Ratio (IV, Random, 95% CI)	1.09 [0.66, 1.81]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.3 Both caesarean and vaginal birth	1	529	Risk Ratio (IV, Random, 95% CI)	1.45 [0.94, 2.24]
7 Additional uterotonics	1	112	Risk Ratio (IV, Random, 95% CI)	1.07 [0.16, 7.36]
7.1 Vaginal birth	1	112	Risk Ratio (IV, Random, 95% CI)	1.07 [0.16, 7.36]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	2	598	Mean Difference (IV, Random, 95% CI)	-26.18 [-104.63, 52.27]
8.1 Vaginal birth	1	69	Mean Difference (IV, Random, 95% CI)	-149.0 [-421.73, 123.73]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.3 Both caesarean and vaginal birth	1	529	Mean Difference (IV, Random, 95% CI)	-15.10 [-97.01, 66.81]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	529	Risk Ratio (IV, Random, 95% CI)	5.06 [1.12, 22.86]
11.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.3 Both caesarean and vaginal birth	1	529	Risk Ratio (IV, Random, 95% CI)	5.06 [1.12, 22.86]
12 Vomiting	1	529	Risk Ratio (IV, Random, 95% CI)	0.92 [0.40, 2.13]

12.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.3 Both caesarean and vaginal birth	1	529	Risk Ratio (IV, Random, 95% CI)	0.92 [0.40, 2.13]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	2	641	Risk Ratio (IV, Random, 95% CI)	23.70 [7.55, 74.45]
18.1 Vaginal birth	1	112	Risk Ratio (IV, Random, 95% CI)	17.19 [2.36, 125.22]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.3 Both caesarean and vaginal birth	1	529	Risk Ratio (IV, Random, 95% CI)	27.81 [6.86, 112.85]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 50. Misoprostol plus oxytocin vs Injectable prostaglandins (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 51. Ergometrine vs Carbetocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 52. Carbetocin vs Ergometrine plus oxytocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	2	320	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	2	320	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	4	1210	Risk Ratio (IV, Random, 95% CI)	0.34 [0.13, 0.86]
2.1 Vaginal birth	3	910	Risk Ratio (IV, Random, 95% CI)	0.69 [0.11, 4.38]
2.2 Caesarean	1	300	Risk Ratio (IV, Random, 95% CI)	0.27 [0.09, 0.78]
3 Blood transfusion	4	1030	Risk Ratio (IV, Random, 95% CI)	1.42 [0.42, 4.82]
3.1 Vaginal birth	4	1030	Risk Ratio (IV, Random, 95% CI)	1.42 [0.42, 4.82]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	2	320	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	2	320	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	4	1030	Risk Ratio (IV, Random, 95% CI)	0.96 [0.44, 2.09]
6.1 Vaginal birth	4	1030	Risk Ratio (IV, Random, 95% CI)	0.96 [0.44, 2.09]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	6	1530	Risk Ratio (IV, Random, 95% CI)	0.54 [0.30, 1.00]
7.1 Vaginal birth	5	1230	Risk Ratio (IV, Random, 95% CI)	0.73 [0.44, 1.21]
7.2 Caesarean	1	300	Risk Ratio (IV, Random, 95% CI)	0.19 [0.08, 0.49]
8 Blood loss	5	1330	Mean Difference (IV, Random, 95% CI)	-44.08 [-82.41, -5.75]
8.1 Vaginal birth	4	1030	Mean Difference (IV, Random, 95% CI)	-48.84 [-94.82, -2.85]

8.2 Caesarean	1	300	Mean Difference (IV, Random, 95% CI)	-24.0 [-68.42, 20.42]
9 Change in haemoglobin	5	1160	Mean Difference (IV, Random, 95% CI)	-2.57 [-4.32, -0.82]
9.1 Vaginal birth	4	860	Mean Difference (IV, Random, 95% CI)	-2.86 [-4.81, -0.90]
9.2 Caesarean	1	300	Mean Difference (IV, Random, 95% CI)	-1.0 [-3.83, 1.83]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	6	1530	Risk Ratio (IV, Random, 95% CI)	0.29 [0.19, 0.45]
11.1 Vaginal birth	5	1230	Risk Ratio (IV, Random, 95% CI)	0.27 [0.16, 0.43]
11.2 Caesarean	1	300	Risk Ratio (IV, Random, 95% CI)	0.45 [0.16, 1.28]
12 Vomiting	6	1530	Risk Ratio (IV, Random, 95% CI)	0.27 [0.16, 0.46]
12.1 Vaginal birth	5	1230	Risk Ratio (IV, Random, 95% CI)	0.24 [0.13, 0.44]
12.2 Caesarean	1	300	Risk Ratio (IV, Random, 95% CI)	0.4 [0.13, 1.25]
13 Headache	5	1330	Risk Ratio (IV, Random, 95% CI)	1.41 [0.45, 4.38]
13.1 Vaginal birth	4	1030	Risk Ratio (IV, Random, 95% CI)	0.83 [0.46, 1.49]
13.2 Caesarean	1	300	Risk Ratio (IV, Random, 95% CI)	8.5 [2.00, 36.15]
14 Abdominal pain	4	930	Risk Ratio (IV, Random, 95% CI)	0.57 [0.36, 0.91]
14.1 Vaginal birth	4	930	Risk Ratio (IV, Random, 95% CI)	0.57 [0.36, 0.91]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	3	660	Risk Ratio (IV, Random, 95% CI)	0.56 [0.22, 1.39]
15.1 Vaginal birth	3	660	Risk Ratio (IV, Random, 95% CI)	0.56 [0.22, 1.39]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	5	1290	Risk Ratio (IV, Random, 95% CI)	0.45 [0.26, 0.80]
16.1 Vaginal birth	4	990	Risk Ratio (IV, Random, 95% CI)	0.40 [0.22, 0.74]
16.2 Caesarean	1	300	Risk Ratio (IV, Random, 95% CI)	1.0 [0.21, 4.88]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 53. Misoprostol plus oxytocin vs Carbetocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	380	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	1	380	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

3 Blood transfusion	1	380	Risk Ratio (IV, Random, 95% CI)	4.00 [0.45, 35.46]
3.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Caesarean	1	380	Risk Ratio (IV, Random, 95% CI)	4.00 [0.45, 35.46]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	1	380	Risk Ratio (IV, Random, 95% CI)	1.19 [0.74, 1.93]
7.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Caesarean	1	380	Risk Ratio (IV, Random, 95% CI)	1.19 [0.74, 1.93]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	1	380	Mean Difference (IV, Random, 95% CI)	-1.70 [-3.72, 0.32]
9.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Caesarean	1	380	Mean Difference (IV, Random, 95% CI)	-1.70 [-3.72, 0.32]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	380	Risk Ratio (IV, Random, 95% CI)	1.21 [0.62, 2.39]
11.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Caesarean	1	380	Risk Ratio (IV, Random, 95% CI)	1.21 [0.62, 2.39]
12 Vomiting	1	380	Risk Ratio (IV, Random, 95% CI)	1.33 [0.58, 3.09]
12.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Caesarean	1	380	Risk Ratio (IV, Random, 95% CI)	1.33 [0.58, 3.09]
13 Headache	1	380	Risk Ratio (IV, Random, 95% CI)	2.0 [0.37, 10.79]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	1	380	Risk Ratio (IV, Random, 95% CI)	2.0 [0.37, 10.79]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	1	380	Risk Ratio (IV, Random, 95% CI)	7.83 [3.43, 17.88]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	1	380	Risk Ratio (IV, Random, 95% CI)	7.83 [3.43, 17.88]
17 Fever	1	380	Risk Ratio (IV, Random, 95% CI)	8.5 [1.99, 36.28]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	1	380	Risk Ratio (IV, Random, 95% CI)	8.5 [1.99, 36.28]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

19.2 Caesarean	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 54. Ergometrine vs Ergometrine plus oxytocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	144	Risk Ratio (IV, Random, 95% CI)	0.17 [0.01, 4.06]
6.1 Vaginal birth	1	144	Risk Ratio (IV, Random, 95% CI)	0.17 [0.01, 4.06]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	1	144	Mean Difference (IV, Random, 95% CI)	20.10 [5.76, 34.44]
8.1 Vaginal birth	1	144	Mean Difference (IV, Random, 95% CI)	20.10 [5.76, 34.44]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 55. Misoprostol plus oxytocin vs Ergometrine (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Vaginal birth	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 56. Misoprostol plus oxytocin vs Ergometrine plus oxytocin (by mode of birth)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	1605	Risk Ratio (IV, Random, 95% CI)	1.41 [0.68, 2.94]

2.1 Vaginal birth	2	1605	Risk Ratio (IV, Random, 95% CI)	1.41 [0.68, 2.94]
2.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	2	1605	Risk Ratio (IV, Random, 95% CI)	0.89 [0.36, 2.19]
3.1 Vaginal birth	2	1605	Risk Ratio (IV, Random, 95% CI)	0.89 [0.36, 2.19]
3.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	2	1605	Risk Ratio (IV, Random, 95% CI)	1.39 [0.65, 2.99]
6.1 Vaginal birth	2	1605	Risk Ratio (IV, Random, 95% CI)	1.39 [0.65, 2.99]
6.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	2	1605	Risk Ratio (IV, Random, 95% CI)	1.48 [0.82, 2.69]
7.1 Vaginal birth	2	1605	Risk Ratio (IV, Random, 95% CI)	1.48 [0.82, 2.69]
7.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	1	802	Mean Difference (IV, Random, 95% CI)	-16.0 [-40.24, 8.24]
8.1 Vaginal birth	1	802	Mean Difference (IV, Random, 95% CI)	-16.0 [-40.24, 8.24]
8.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	2	1605	Mean Difference (IV, Random, 95% CI)	-0.50 [-1.72, 0.72]
9.1 Vaginal birth	2	1605	Mean Difference (IV, Random, 95% CI)	-0.50 [-1.72, 0.72]
9.2 Caesarean	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	2	1605	Risk Ratio (IV, Random, 95% CI)	1.04 [0.23, 4.77]
12.1 Vaginal birth	2	1605	Risk Ratio (IV, Random, 95% CI)	1.04 [0.23, 4.77]
12.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Vaginal birth	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	2	1605	Risk Ratio (IV, Random, 95% CI)	2.95 [2.02, 4.29]
16.1 Vaginal birth	2	1605	Risk Ratio (IV, Random, 95% CI)	2.95 [2.02, 4.29]
16.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	2	1605	Risk Ratio (IV, Random, 95% CI)	2.89 [1.51, 5.54]
17.1 Vaginal birth	2	1605	Risk Ratio (IV, Random, 95% CI)	2.89 [1.51, 5.54]
17.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	2	1605	Risk Ratio (IV, Random, 95% CI)	0.81 [0.46, 1.41]
18.1 Vaginal birth	2	1605	Risk Ratio (IV, Random, 95% CI)	0.81 [0.46, 1.41]
18.2 Caesarean	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

19 Maternal well-being	0	Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Vaginal birth	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Caesarean	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Vaginal birth	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Caesarean	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 57. Oxytocin vs Placebo or no treatment (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	3	1920	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	1	130	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	1	1569	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.3 Both community and hospital setting	1	221	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	11	8782	Risk Ratio (IV, Random, 95% CI)	0.61 [0.51, 0.72]
2.1 Hospital setting	8	5306	Risk Ratio (IV, Random, 95% CI)	0.64 [0.52, 0.79]
2.2 Community setting	2	3255	Risk Ratio (IV, Random, 95% CI)	0.47 [0.22, 0.98]
2.3 Both community and hospital setting	1	221	Risk Ratio (IV, Random, 95% CI)	0.80 [0.34, 1.87]
3 Blood transfusion	8	6717	Risk Ratio (IV, Random, 95% CI)	0.75 [0.51, 1.12]
3.1 Hospital setting	6	4810	Risk Ratio (IV, Random, 95% CI)	0.71 [0.44, 1.14]
3.2 Community setting	1	1686	Risk Ratio (IV, Random, 95% CI)	0.82 [0.36, 1.88]
3.3 Both community and hospital setting	1	221	Risk Ratio (IV, Random, 95% CI)	1.22 [0.21, 7.16]
4 Severe maternal morbidity: intensive care admissions	1	1950	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	1	1950	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.3 Both community and hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.3 Both community and hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	9	7021	Risk Ratio (IV, Random, 95% CI)	0.61 [0.52, 0.71]
6.1 Hospital setting	6	3545	Risk Ratio (IV, Random, 95% CI)	0.54 [0.46, 0.63]
6.2 Community setting	2	3255	Risk Ratio (IV, Random, 95% CI)	0.64 [0.43, 0.95]
6.3 Both community and hospital setting	1	221	Risk Ratio (IV, Random, 95% CI)	0.83 [0.57, 1.22]
7 Additional uterotonics	8	5047	Risk Ratio (IV, Random, 95% CI)	0.43 [0.32, 0.58]
7.1 Hospital setting	6	3154	Risk Ratio (IV, Random, 95% CI)	0.38 [0.27, 0.53]
7.2 Community setting	1	1672	Risk Ratio (IV, Random, 95% CI)	0.40 [0.31, 0.51]
7.3 Both community and hospital setting	1	221	Risk Ratio (IV, Random, 95% CI)	0.99 [0.55, 1.78]

8 Blood loss	8	3521	Mean Difference (IV, Random, 95% CI)	-118.52 [-141.40, -95.64]
8.1 Hospital setting	7	3300	Mean Difference (IV, Random, 95% CI)	-122.08 [-145.37, -98.79]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.3 Both community and hospital setting	1	221	Mean Difference (IV, Random, 95% CI)	-21.0 [-142.93, 100.93]
9 Change in haemoglobin	5	2304	Mean Difference (IV, Random, 95% CI)	-2.68 [-4.47, -0.89]
9.1 Hospital setting	5	2304	Mean Difference (IV, Random, 95% CI)	-2.68 [-4.47, -0.89]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.3 Both community and hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	1	1540	Risk Ratio (IV, Random, 95% CI)	1.00 [0.95, 1.05]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	1	1540	Risk Ratio (IV, Random, 95% CI)	1.00 [0.95, 1.05]
10.3 Both community and hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	3	1788	Risk Ratio (IV, Random, 95% CI)	0.82 [0.47, 1.42]
11.1 Hospital setting	2	126	Risk Ratio (IV, Random, 95% CI)	0.27 [0.03, 2.10]
11.2 Community setting	1	1662	Risk Ratio (IV, Random, 95% CI)	0.89 [0.51, 1.58]
11.3 Both community and hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	3	2150	Risk Ratio (IV, Random, 95% CI)	1.40 [0.44, 4.41]
12.1 Hospital setting	2	490	Risk Ratio (IV, Random, 95% CI)	1.12 [0.07, 17.83]
12.2 Community setting	1	1660	Risk Ratio (IV, Random, 95% CI)	1.46 [0.41, 5.17]
12.3 Both community and hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	2	1704	Risk Ratio (IV, Random, 95% CI)	1.56 [0.52, 4.74]
13.1 Hospital setting	1	51	Risk Ratio (IV, Random, 95% CI)	6.74 [0.37, 124.21]
13.2 Community setting	1	1653	Risk Ratio (IV, Random, 95% CI)	1.26 [0.63, 2.51]
13.3 Both community and hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	1	1665	Risk Ratio (IV, Random, 95% CI)	0.89 [0.80, 1.00]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	1	1665	Risk Ratio (IV, Random, 95% CI)	0.89 [0.80, 1.00]
14.3 Both community and hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.3 Both community and hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	1	416	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Hospital setting	1	416	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.3 Both community and hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	1	416	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	1	416	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.3 Both community and hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.3 Both community and hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal sense of well-being	1		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting - Women's perceptions of well-being at 3 months postpartum: Less energy than before birth	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.3 Community setting - Women's perceptions of well-being at 3 months postpartum: Experiencing (some) fatigue	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.4 Both community and hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	1		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting - Did management influence positively the childbirth experiences of the mothers?	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Hospital setting - Did management influence negatively the childbirth experiences of the mothers?	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.3 Hospital setting - Did management make no difference in the childbirth experiences of the mothers?	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.4 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.5 Both community and hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 58. Carbetocin vs Placebo or no treatment (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	50	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Hospital setting	1	50	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	50	Risk Ratio (IV, Random, 95% CI)	0.75 [0.30, 1.85]
6.1 Hospital setting	1	50	Risk Ratio (IV, Random, 95% CI)	0.75 [0.30, 1.85]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	2	169	Risk Ratio (IV, Random, 95% CI)	0.19 [0.12, 0.32]
7.1 Hospital setting	2	169	Risk Ratio (IV, Random, 95% CI)	0.19 [0.12, 0.32]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	1	50	Mean Difference (IV, Random, 95% CI)	-274.0 [-591.60, 43.60]
8.1 Hospital setting	1	50	Mean Difference (IV, Random, 95% CI)	-274.0 [-591.60, 43.60]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	1	50	Mean Difference (IV, Random, 95% CI)	-3.40 [-7.23, 0.43]
9.1 Hospital setting	1	50	Mean Difference (IV, Random, 95% CI)	-3.40 [-7.23, 0.43]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	1	50	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
13.1 Hospital setting	1	50	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

20 Maternal satisfaction	0	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 59. Misoprostol vs Placebo or no treatment (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	4	3497	Risk Ratio (IV, Random, 95% CI)	1.00 [0.10, 9.59]
1.1 Hospital setting	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	3	3397	Risk Ratio (IV, Random, 95% CI)	1.00 [0.10, 9.59]
2 PPH >= 1000 mL	8	5467	Risk Ratio (IV, Random, 95% CI)	0.73 [0.56, 0.95]
2.1 Hospital setting	5	2114	Risk Ratio (IV, Random, 95% CI)	0.85 [0.63, 1.15]
2.2 Community setting	3	3353	Risk Ratio (IV, Random, 95% CI)	0.59 [0.39, 0.88]
3 Blood transfusion	6	3134	Risk Ratio (IV, Random, 95% CI)	0.46 [0.15, 1.47]
3.1 Hospital setting	5	1514	Risk Ratio (IV, Random, 95% CI)	0.77 [0.19, 3.10]
3.2 Community setting	1	1620	Risk Ratio (IV, Random, 95% CI)	0.14 [0.02, 1.15]
4 Severe maternal morbidity: intensive care admissions	1	1620	Risk Ratio (IV, Random, 95% CI)	1.00 [0.14, 7.05]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	1	1620	Risk Ratio (IV, Random, 95% CI)	1.00 [0.14, 7.05]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	7	4047	Risk Ratio (IV, Random, 95% CI)	0.75 [0.59, 0.94]
6.1 Hospital setting	4	694	Risk Ratio (IV, Random, 95% CI)	0.60 [0.29, 1.25]
6.2 Community setting	3	3353	Risk Ratio (IV, Random, 95% CI)	0.73 [0.56, 0.96]
7 Additional uterotonics	8	3746	Risk Ratio (IV, Random, 95% CI)	0.67 [0.52, 0.87]
7.1 Hospital setting	7	2126	Risk Ratio (IV, Random, 95% CI)	0.68 [0.52, 0.88]
7.2 Community setting	1	1620	Risk Ratio (IV, Random, 95% CI)	0.50 [0.12, 1.98]
8 Blood loss	8	4146	Mean Difference (IV, Random, 95% CI)	-42.07 [-52.47, -31.68]
8.1 Hospital setting	5	794	Mean Difference (IV, Random, 95% CI)	-41.82 [-61.16, -22.49]
8.2 Community setting	3	3352	Mean Difference (IV, Random, 95% CI)	-43.79 [-58.09, -29.49]
9 Change in haemoglobin	5	2334	Mean Difference (IV, Random, 95% CI)	-2.53 [-3.53, -1.52]
9.1 Hospital setting	3	573	Mean Difference (IV, Random, 95% CI)	-2.05 [-4.30, 0.19]
9.2 Community setting	2	1761	Mean Difference (IV, Random, 95% CI)	-2.12 [-3.46, -0.77]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	4	3997	Risk Ratio (IV, Random, 95% CI)	1.18 [0.78, 1.78]
11.1 Hospital setting	1	600	Risk Ratio (IV, Random, 95% CI)	5.00 [0.59, 42.54]
11.2 Community setting	3	3397	Risk Ratio (IV, Random, 95% CI)	1.12 [0.74, 1.70]
12 Vomiting	6	4949	Risk Ratio (IV, Random, 95% CI)	1.41 [0.92, 2.16]
12.1 Hospital setting	3	1552	Risk Ratio (IV, Random, 95% CI)	2.79 [0.85, 9.15]

12.2 Community setting	3	3397	Risk Ratio (IV, Random, 95% CI)	1.27 [0.80, 2.01]
13 Headache	1	1116	Risk Ratio (IV, Random, 95% CI)	0.94 [0.32, 2.77]
13.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Community setting	1	1116	Risk Ratio (IV, Random, 95% CI)	0.94 [0.32, 2.77]
14 Abdominal pain	4	1894	Risk Ratio (IV, Random, 95% CI)	0.98 [0.29, 3.37]
14.1 Hospital setting	4	1894	Risk Ratio (IV, Random, 95% CI)	0.98 [0.29, 3.37]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	9	5286	Risk Ratio (IV, Random, 95% CI)	2.94 [2.38, 3.64]
16.1 Hospital setting	6	1889	Risk Ratio (IV, Random, 95% CI)	3.55 [2.13, 5.90]
16.2 Community setting	3	3397	Risk Ratio (IV, Random, 95% CI)	2.71 [2.33, 3.15]
17 Fever	5	4396	Risk Ratio (IV, Random, 95% CI)	4.09 [2.01, 8.32]
17.1 Hospital setting	2	999	Risk Ratio (IV, Random, 95% CI)	6.38 [4.01, 10.14]
17.2 Community setting	3	3397	Risk Ratio (IV, Random, 95% CI)	2.87 [0.90, 9.18]
18 Diarrhoea	6	4791	Risk Ratio (IV, Random, 95% CI)	2.80 [1.21, 6.49]
18.1 Hospital setting	3	1394	Risk Ratio (IV, Random, 95% CI)	1.0 [0.06, 15.91]
18.2 Community setting	3	3397	Risk Ratio (IV, Random, 95% CI)	3.11 [1.28, 7.51]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 60. Injectable prostaglandins vs Placebo or no treatment (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	46	Risk Ratio (IV, Random, 95% CI)	0.36 [0.04, 3.24]
2.1 Hospital setting	1	46	Risk Ratio (IV, Random, 95% CI)	0.36 [0.04, 3.24]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Hospital setting	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	46	Risk Ratio (IV, Random, 95% CI)	0.55 [0.22, 1.35]
6.1 Hospital setting	1	46	Risk Ratio (IV, Random, 95% CI)	0.55 [0.22, 1.35]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	2	146	Risk Ratio (IV, Random, 95% CI)	0.66 [0.21, 2.09]

7.1 Hospital setting	2	146	Risk Ratio (IV, Random, 95% CI)	0.66 [0.21, 2.09]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	2	146	Mean Difference (IV, Random, 95% CI)	-95.17 [-296.09, 105.75]
8.1 Hospital setting	2	146	Mean Difference (IV, Random, 95% CI)	-95.17 [-296.09, 105.75]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	1	100	Mean Difference (IV, Random, 95% CI)	0.90 [0.56, 1.24]
9.1 Hospital setting	1	100	Mean Difference (IV, Random, 95% CI)	0.90 [0.56, 1.24]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	46	Risk Ratio (IV, Random, 95% CI)	0.36 [0.02, 8.46]
11.1 Hospital setting	1	46	Risk Ratio (IV, Random, 95% CI)	0.36 [0.02, 8.46]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 61. Ergometrine vs Placebo or no treatment (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	1429	Risk Ratio (IV, Random, 95% CI)	0.09 [0.01, 0.72]
2.1 Hospital setting	1	1429	Risk Ratio (IV, Random, 95% CI)	0.09 [0.01, 0.72]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	2	1529	Risk Ratio (IV, Random, 95% CI)	0.34 [0.04, 3.28]
3.1 Hospital setting	2	1529	Risk Ratio (IV, Random, 95% CI)	0.34 [0.04, 3.28]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	1429	Risk Ratio (IV, Random, 95% CI)	0.24 [0.14, 0.42]
6.1 Hospital setting	1	1429	Risk Ratio (IV, Random, 95% CI)	0.24 [0.14, 0.42]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	2	1529	Risk Ratio (IV, Random, 95% CI)	0.18 [0.09, 0.37]
7.1 Hospital setting	2	1529	Risk Ratio (IV, Random, 95% CI)	0.18 [0.09, 0.37]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	2	1529	Mean Difference (IV, Random, 95% CI)	-50.64 [-119.92, 18.65]
8.1 Hospital setting	2	1529	Mean Difference (IV, Random, 95% CI)	-50.64 [-119.92, 18.65]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	1	100	Mean Difference (IV, Random, 95% CI)	-0.5 [-0.58, -0.42]
9.1 Hospital setting	1	100	Mean Difference (IV, Random, 95% CI)	-0.5 [-0.58, -0.42]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	1429	Risk Ratio (IV, Random, 95% CI)	42.10 [2.55, 694.80]
11.1 Hospital setting	1	1429	Risk Ratio (IV, Random, 95% CI)	42.10 [2.55, 694.80]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	1	1429	Risk Ratio (IV, Random, 95% CI)	25.67 [1.52, 432.78]
12.1 Hospital setting	1	1429	Risk Ratio (IV, Random, 95% CI)	25.67 [1.52, 432.78]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	1	1429	Risk Ratio (IV, Random, 95% CI)	7.19 [0.37, 138.91]
13.1 Hospital setting	1	1429	Risk Ratio (IV, Random, 95% CI)	7.19 [0.37, 138.91]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	1	1429	Risk Ratio (IV, Random, 95% CI)	2.05 [1.04, 4.08]
14.1 Hospital setting	1	1429	Risk Ratio (IV, Random, 95% CI)	2.05 [1.04, 4.08]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	1	1429	Risk Ratio (IV, Random, 95% CI)	7.19 [2.83, 18.24]

15.1 Hospital setting	1	1429	Risk Ratio (IV, Random, 95% CI)	7.19 [2.83, 18.24]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 62. Ergometrine plus oxytocin vs Placebo or no treatment (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	3207	Risk Ratio (IV, Random, 95% CI)	0.44 [0.18, 1.05]
2.1 Hospital setting	2	3207	Risk Ratio (IV, Random, 95% CI)	0.44 [0.18, 1.05]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	3	3400	Risk Ratio (IV, Random, 95% CI)	0.34 [0.18, 0.66]
3.1 Hospital setting	3	3400	Risk Ratio (IV, Random, 95% CI)	0.34 [0.18, 0.66]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	2	3207	Risk Ratio (IV, Random, 95% CI)	0.37 [0.30, 0.46]
6.1 Hospital setting	2	3207	Risk Ratio (IV, Random, 95% CI)	0.37 [0.30, 0.46]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	3	3400	Risk Ratio (IV, Random, 95% CI)	0.19 [0.15, 0.24]
7.1 Hospital setting	3	3400	Risk Ratio (IV, Random, 95% CI)	0.19 [0.15, 0.24]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	2	1705	Mean Difference (IV, Random, 95% CI)	-35.02 [-101.63, 31.59]
8.1 Hospital setting	2	1705	Mean Difference (IV, Random, 95% CI)	-35.02 [-101.63, 31.59]

8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	2	1454	Mean Difference (IV, Random, 95% CI)	-3.57 [-6.50, -0.63]
9.1 Hospital setting	2	1454	Mean Difference (IV, Random, 95% CI)	-3.57 [-6.50, -0.63]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	2	3207	Risk Ratio (IV, Random, 95% CI)	1.03 [0.99, 1.07]
10.1 Hospital setting	2	3207	Risk Ratio (IV, Random, 95% CI)	1.03 [0.99, 1.07]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	1512	Risk Ratio (IV, Random, 95% CI)	1.95 [1.38, 2.76]
11.1 Hospital setting	1	1512	Risk Ratio (IV, Random, 95% CI)	1.95 [1.38, 2.76]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	2	3207	Risk Ratio (IV, Random, 95% CI)	2.15 [1.46, 3.18]
12.1 Hospital setting	2	3207	Risk Ratio (IV, Random, 95% CI)	2.15 [1.46, 3.18]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	2	3207	Risk Ratio (IV, Random, 95% CI)	1.65 [0.78, 3.48]
13.1 Hospital setting	2	3207	Risk Ratio (IV, Random, 95% CI)	1.65 [0.78, 3.48]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	1		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting - General health at 6 weeks postpartum (Worse than prepregnancy)	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Hospital setting - General health at 6 weeks postpartum (Exhausted since birth)	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.3 Hospital setting - General health at 6 weeks postpartum (Exhausted at 6 weeks)	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.4 Hospital setting - General health at 6 weeks postpartum (Blues)	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.5 Hospital setting - General health at 6 weeks postpartum (Depressed)	1		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

19.6 Hospital setting - General health at 6 weeks postpartum (Help for depression)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.7 Hospital setting - General health at 6 weeks postpartum (Admission to hospital for depression)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.8 Hospital setting - General health at 6 weeks postpartum (No health problems reported)	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.9 Community setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	1	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting - Satisfied with third-stage management	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Hospital setting - Felt in control during third stage	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.3 Community setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 63. Misoprostol plus oxytocin vs Placebo or no treatment (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]

8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 64. Misoprostol vs Oxytocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	24	28520	Risk Ratio (IV, Random, 95% CI)	0.62 [0.14, 2.74]
1.1 Hospital setting	23	28127	Risk Ratio (IV, Random, 95% CI)	0.62 [0.14, 2.74]
1.2 Community setting	1	393	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	38	34261	Risk Ratio (IV, Random, 95% CI)	1.26 [1.11, 1.43]
2.1 Hospital setting	38	34261	Risk Ratio (IV, Random, 95% CI)	1.26 [1.11, 1.43]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	42	35467	Risk Ratio (IV, Random, 95% CI)	0.81 [0.65, 1.00]

3.1 Hospital setting	42	35467	Risk Ratio (IV, Random, 95% CI)	0.81 [0.65, 1.00]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	10	21698	Risk Ratio (IV, Random, 95% CI)	1.16 [0.55, 2.43]
4.1 Hospital setting	10	21698	Risk Ratio (IV, Random, 95% CI)	1.16 [0.55, 2.43]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	44	36920	Risk Ratio (IV, Random, 95% CI)	1.08 [0.94, 1.24]
6.1 Hospital setting	44	36920	Risk Ratio (IV, Random, 95% CI)	1.08 [0.94, 1.24]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	47	35981	Risk Ratio (IV, Random, 95% CI)	1.01 [0.85, 1.20]
7.1 Hospital setting	47	35981	Risk Ratio (IV, Random, 95% CI)	1.01 [0.85, 1.20]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	43	35239	Mean Difference (IV, Random, 95% CI)	-8.90 [-23.45, 5.65]
8.1 Hospital setting	43	35239	Mean Difference (IV, Random, 95% CI)	-8.90 [-23.45, 5.65]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	31	12028	Mean Difference (IV, Random, 95% CI)	-0.14 [-0.74, 0.47]
9.1 Hospital setting	30	11724	Mean Difference (IV, Random, 95% CI)	-0.15 [-0.77, 0.46]
9.2 Community setting	1	304	Mean Difference (IV, Random, 95% CI)	0.76 [-3.21, 4.73]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	33	29732	Risk Ratio (IV, Random, 95% CI)	1.22 [0.93, 1.60]
11.1 Hospital setting	32	29339	Risk Ratio (IV, Random, 95% CI)	1.22 [0.93, 1.61]
11.2 Community setting	1	393	Risk Ratio (IV, Random, 95% CI)	0.84 [0.14, 4.96]
12 Vomiting	41	32687	Risk Ratio (IV, Random, 95% CI)	1.51 [1.19, 1.91]
12.1 Hospital setting	40	32294	Risk Ratio (IV, Random, 95% CI)	1.48 [1.16, 1.89]
12.2 Community setting	1	393	Risk Ratio (IV, Random, 95% CI)	2.81 [0.14, 58.05]
13 Headache	10	4079	Risk Ratio (IV, Random, 95% CI)	0.88 [0.54, 1.42]
13.1 Hospital setting	10	4079	Risk Ratio (IV, Random, 95% CI)	0.88 [0.54, 1.42]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	8	3382	Risk Ratio (IV, Random, 95% CI)	0.91 [0.79, 1.06]
14.1 Hospital setting	8	3382	Risk Ratio (IV, Random, 95% CI)	0.91 [0.79, 1.06]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	3	1028	Risk Ratio (IV, Random, 95% CI)	3.64 [0.60, 22.27]
15.1 Hospital setting	3	1028	Risk Ratio (IV, Random, 95% CI)	3.64 [0.60, 22.27]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	49	34865	Risk Ratio (IV, Random, 95% CI)	4.02 [3.23, 4.99]
16.1 Hospital setting	48	34534	Risk Ratio (IV, Random, 95% CI)	3.82 [3.09, 4.74]
16.2 Community setting	1	331	Risk Ratio (IV, Random, 95% CI)	16.13 [7.81, 33.31]
17 Fever	41	33008	Risk Ratio (IV, Random, 95% CI)	3.75 [2.73, 5.15]
17.1 Hospital setting	40	32615	Risk Ratio (IV, Random, 95% CI)	3.80 [2.76, 5.25]
17.2 Community setting	1	393	Risk Ratio (IV, Random, 95% CI)	2.24 [0.48, 10.40]
18 Diarrhoea	26	30733	Risk Ratio (IV, Random, 95% CI)	2.13 [1.55, 2.93]
18.1 Hospital setting	25	30340	Risk Ratio (IV, Random, 95% CI)	2.17 [1.57, 2.99]
18.2 Community setting	1	393	Risk Ratio (IV, Random, 95% CI)	0.56 [0.04, 8.88]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

20 Maternal satisfaction	1	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting - Complaints about or problems with drug	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.3 Community setting - Satisfied or very satisfied with drug	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.4 Community setting - Would take drug again after subsequent deliveries	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.5 Community setting - Would recommend drug to a friend	1	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 65. Injectable prostaglandins vs Oxytocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	200	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	1	200	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	100	Risk Ratio (IV, Random, 95% CI)	1.43 [0.20, 10.31]
2.1 Hospital setting	2	100	Risk Ratio (IV, Random, 95% CI)	1.43 [0.20, 10.31]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	2	250	Risk Ratio (IV, Random, 95% CI)	1.01 [0.04, 23.65]
3.1 Hospital setting	2	250	Risk Ratio (IV, Random, 95% CI)	1.01 [0.04, 23.65]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	4	500	Risk Ratio (IV, Random, 95% CI)	0.84 [0.26, 2.71]
6.1 Hospital setting	4	500	Risk Ratio (IV, Random, 95% CI)	0.84 [0.26, 2.71]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	4	500	Risk Ratio (IV, Random, 95% CI)	0.29 [0.09, 0.94]
7.1 Hospital setting	4	500	Risk Ratio (IV, Random, 95% CI)	0.29 [0.09, 0.94]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	4	500	Mean Difference (IV, Random, 95% CI)	-15.83 [-152.28, 120.62]
8.1 Hospital setting	4	500	Mean Difference (IV, Random, 95% CI)	-15.83 [-152.28, 120.62]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]

9.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	3	450	Risk Ratio (IV, Random, 95% CI)	1.17 [0.40, 3.41]
11.1 Hospital setting	3	450	Risk Ratio (IV, Random, 95% CI)	1.17 [0.40, 3.41]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	2	400	Risk Ratio (IV, Random, 95% CI)	2.48 [0.57, 10.73]
12.1 Hospital setting	2	400	Risk Ratio (IV, Random, 95% CI)	2.48 [0.57, 10.73]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	1	200	Risk Ratio (IV, Random, 95% CI)	0.20 [0.01, 4.11]
13.1 Hospital setting	1	200	Risk Ratio (IV, Random, 95% CI)	0.20 [0.01, 4.11]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	2	400	Risk Ratio (IV, Random, 95% CI)	0.91 [0.11, 7.73]
16.1 Hospital setting	2	400	Risk Ratio (IV, Random, 95% CI)	0.91 [0.11, 7.73]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	1	200	Risk Ratio (IV, Random, 95% CI)	2.0 [0.18, 21.71]
17.1 Hospital setting	1	200	Risk Ratio (IV, Random, 95% CI)	2.0 [0.18, 21.71]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	2	400	Risk Ratio (IV, Random, 95% CI)	10.38 [1.96, 54.98]
18.1 Hospital setting	2	400	Risk Ratio (IV, Random, 95% CI)	10.38 [1.96, 54.98]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 66. Carbetocin vs Oxytocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	5	30327	Risk Ratio (IV, Random, 95% CI)	2.00 [0.37, 10.92]
1.1 Hospital setting	5	30327	Risk Ratio (IV, Random, 95% CI)	2.00 [0.37, 10.92]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	10	30633	Risk Ratio (IV, Random, 95% CI)	0.73 [0.45, 1.19]
2.1 Hospital setting	10	30633	Risk Ratio (IV, Random, 95% CI)	0.73 [0.45, 1.19]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	16	32115	Risk Ratio (IV, Random, 95% CI)	0.68 [0.38, 1.22]
3.1 Hospital setting	16	32115	Risk Ratio (IV, Random, 95% CI)	0.68 [0.38, 1.22]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

4 Severe maternal morbidity: intensive care admissions	2	29847	Risk Ratio (IV, Random, 95% CI)	1.16 [0.67, 2.02]
4.1 Hospital setting	2	29847	Risk Ratio (IV, Random, 95% CI)	1.16 [0.67, 2.02]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	11	30633	Risk Ratio (IV, Random, 95% CI)	0.75 [0.58, 0.98]
6.1 Hospital setting	11	30633	Risk Ratio (IV, Random, 95% CI)	0.75 [0.58, 0.98]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	22	32699	Risk Ratio (IV, Random, 95% CI)	0.48 [0.34, 0.68]
7.1 Hospital setting	22	32699	Risk Ratio (IV, Random, 95% CI)	0.48 [0.34, 0.68]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	16	2115	Mean Difference (IV, Random, 95% CI)	-92.73 [-154.97, -30.49]
8.1 Hospital setting	16	2115	Mean Difference (IV, Random, 95% CI)	-92.73 [-154.97, -30.49]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	12	2096	Mean Difference (IV, Random, 95% CI)	-1.66 [-3.81, 0.50]
9.1 Hospital setting	12	2096	Mean Difference (IV, Random, 95% CI)	-1.66 [-3.81, 0.50]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	2	190	Risk Ratio (IV, Random, 95% CI)	0.94 [0.86, 1.03]
10.1 Hospital setting	2	190	Risk Ratio (IV, Random, 95% CI)	0.94 [0.86, 1.03]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	12	2288	Risk Ratio (IV, Random, 95% CI)	1.11 [0.78, 1.56]
11.1 Hospital setting	12	2288	Risk Ratio (IV, Random, 95% CI)	1.11 [0.78, 1.56]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	13	31833	Risk Ratio (IV, Random, 95% CI)	0.90 [0.53, 1.50]
12.1 Hospital setting	13	31833	Risk Ratio (IV, Random, 95% CI)	0.90 [0.53, 1.50]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	15	2620	Risk Ratio (IV, Random, 95% CI)	0.84 [0.63, 1.12]
13.1 Hospital setting	15	2620	Risk Ratio (IV, Random, 95% CI)	0.84 [0.63, 1.12]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	10	31293	Risk Ratio (IV, Random, 95% CI)	1.18 [0.97, 1.44]
14.1 Hospital setting	10	31293	Risk Ratio (IV, Random, 95% CI)	1.18 [0.97, 1.44]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	9	1998	Risk Ratio (IV, Random, 95% CI)	0.78 [0.49, 1.23]
16.1 Hospital setting	9	1998	Risk Ratio (IV, Random, 95% CI)	0.78 [0.49, 1.23]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	4	466	Risk Ratio (IV, Random, 95% CI)	1.58 [0.27, 9.35]
17.1 Hospital setting	4	466	Risk Ratio (IV, Random, 95% CI)	1.58 [0.27, 9.35]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

20 Maternal satisfaction	0	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 67. Ergometrine vs Oxytocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	1293	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	1	1293	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	6	2591	Risk Ratio (IV, Random, 95% CI)	1.30 [0.52, 3.27]
2.1 Hospital setting	6	2591	Risk Ratio (IV, Random, 95% CI)	1.30 [0.52, 3.27]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	5	1893	Risk Ratio (IV, Random, 95% CI)	1.44 [0.20, 10.23]
3.1 Hospital setting	5	1893	Risk Ratio (IV, Random, 95% CI)	1.44 [0.20, 10.23]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	10	3221	Risk Ratio (IV, Random, 95% CI)	1.31 [0.86, 1.99]
6.1 Hospital setting	10	3221	Risk Ratio (IV, Random, 95% CI)	1.31 [0.86, 1.99]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	6	2493	Risk Ratio (IV, Random, 95% CI)	1.46 [0.61, 3.48]
7.1 Hospital setting	6	2493	Risk Ratio (IV, Random, 95% CI)	1.46 [0.61, 3.48]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	10	3221	Mean Difference (IV, Random, 95% CI)	8.09 [-17.83, 34.00]
8.1 Hospital setting	10	3221	Mean Difference (IV, Random, 95% CI)	8.09 [-17.83, 34.00]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	2	1893	Mean Difference (IV, Random, 95% CI)	0.42 [-0.30, 1.13]
9.1 Hospital setting	2	1893	Mean Difference (IV, Random, 95% CI)	0.42 [-0.30, 1.13]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	6	2529	Risk Ratio (IV, Random, 95% CI)	4.56 [1.13, 18.44]
11.1 Hospital setting	6	2529	Risk Ratio (IV, Random, 95% CI)	4.56 [1.13, 18.44]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	5	2343	Risk Ratio (IV, Random, 95% CI)	3.83 [1.10, 13.28]
12.1 Hospital setting	5	2343	Risk Ratio (IV, Random, 95% CI)	3.83 [1.10, 13.28]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	4	2293	Risk Ratio (IV, Random, 95% CI)	5.63 [0.93, 33.96]
13.1 Hospital setting	4	2293	Risk Ratio (IV, Random, 95% CI)	5.63 [0.93, 33.96]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	3	1410	Risk Ratio (IV, Random, 95% CI)	13.39 [2.01, 89.44]
15.1 Hospital setting	3	1410	Risk Ratio (IV, Random, 95% CI)	13.39 [2.01, 89.44]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	3	1493	Risk Ratio (IV, Random, 95% CI)	1.73 [0.93, 3.25]
16.1 Hospital setting	3	1493	Risk Ratio (IV, Random, 95% CI)	1.73 [0.93, 3.25]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	2	1443	Risk Ratio (IV, Random, 95% CI)	2.97 [0.97, 9.05]
17.1 Hospital setting	2	1443	Risk Ratio (IV, Random, 95% CI)	2.97 [0.97, 9.05]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	2	1393	Risk Ratio (IV, Random, 95% CI)	3.74 [0.42, 33.53]
18.1 Hospital setting	2	1393	Risk Ratio (IV, Random, 95% CI)	3.74 [0.42, 33.53]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 68. Ergometine plus oxytocin vs Oxytocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	2	1314	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	2	1314	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	10	10990	Risk Ratio (IV, Random, 95% CI)	0.73 [0.57, 0.93]
2.1 Hospital setting	10	10990	Risk Ratio (IV, Random, 95% CI)	0.73 [0.57, 0.93]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	11	10985	Risk Ratio (IV, Random, 95% CI)	0.88 [0.53, 1.44]
3.1 Hospital setting	11	10985	Risk Ratio (IV, Random, 95% CI)	0.88 [0.53, 1.44]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	1	991	Risk Ratio (IV, Random, 95% CI)	2.99 [0.12, 73.32]
4.1 Hospital setting	1	991	Risk Ratio (IV, Random, 95% CI)	2.99 [0.12, 73.32]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	11	11090	Risk Ratio (IV, Random, 95% CI)	0.72 [0.57, 0.91]
6.1 Hospital setting	11	11090	Risk Ratio (IV, Random, 95% CI)	0.72 [0.57, 0.91]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	10	8968	Risk Ratio (IV, Random, 95% CI)	0.79 [0.59, 1.07]
7.1 Hospital setting	10	8968	Risk Ratio (IV, Random, 95% CI)	0.79 [0.59, 1.07]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

8 Blood loss	10	4248	Mean Difference (IV, Random, 95% CI)	-10.31 [-40.32, 19.70]
8.1 Hospital setting	10	4248	Mean Difference (IV, Random, 95% CI)	-10.31 [-40.32, 19.70]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	6	4324	Mean Difference (IV, Random, 95% CI)	-2.23 [-5.24, 0.77]
9.1 Hospital setting	6	4324	Mean Difference (IV, Random, 95% CI)	-2.23 [-5.24, 0.77]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	1	3483	Risk Ratio (IV, Random, 95% CI)	0.99 [0.96, 1.01]
10.1 Hospital setting	1	3483	Risk Ratio (IV, Random, 95% CI)	0.99 [0.96, 1.01]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	7	6931	Risk Ratio (IV, Random, 95% CI)	1.72 [0.84, 3.53]
11.1 Hospital setting	7	6931	Risk Ratio (IV, Random, 95% CI)	1.72 [0.84, 3.53]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	9	10227	Risk Ratio (IV, Random, 95% CI)	3.05 [1.76, 5.29]
12.1 Hospital setting	9	10227	Risk Ratio (IV, Random, 95% CI)	3.05 [1.76, 5.29]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	5	5105	Risk Ratio (IV, Random, 95% CI)	1.26 [0.79, 1.99]
13.1 Hospital setting	5	5105	Risk Ratio (IV, Random, 95% CI)	1.26 [0.79, 1.99]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	3	1362	Risk Ratio (IV, Random, 95% CI)	2.00 [0.29, 13.97]
15.1 Hospital setting	3	1362	Risk Ratio (IV, Random, 95% CI)	2.00 [0.29, 13.97]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	2	1591	Risk Ratio (IV, Random, 95% CI)	0.96 [0.60, 1.53]
16.1 Hospital setting	2	1591	Risk Ratio (IV, Random, 95% CI)	0.96 [0.60, 1.53]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	2	1591	Risk Ratio (IV, Random, 95% CI)	1.08 [0.48, 2.43]
17.1 Hospital setting	2	1591	Risk Ratio (IV, Random, 95% CI)	1.08 [0.48, 2.43]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	3	2030	Risk Ratio (IV, Random, 95% CI)	1.26 [0.72, 2.22]
18.1 Hospital setting	3	2030	Risk Ratio (IV, Random, 95% CI)	1.26 [0.72, 2.22]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 69. Misoprostol plus oxytocin vs Oxytocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	9	4737	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	9	4737	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	17	8514	Risk Ratio (IV, Random, 95% CI)	0.87 [0.69, 1.09]
2.1 Hospital setting	17	8514	Risk Ratio (IV, Random, 95% CI)	0.87 [0.69, 1.09]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	19	8742	Risk Ratio (IV, Random, 95% CI)	0.50 [0.37, 0.67]
3.1 Hospital setting	19	8742	Risk Ratio (IV, Random, 95% CI)	0.50 [0.37, 0.67]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	3	1886	Risk Ratio (IV, Random, 95% CI)	0.50 [0.05, 5.47]
4.1 Hospital setting	3	1886	Risk Ratio (IV, Random, 95% CI)	0.50 [0.05, 5.47]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	14	8148	Risk Ratio (IV, Random, 95% CI)	0.71 [0.59, 0.85]
6.1 Hospital setting	14	8148	Risk Ratio (IV, Random, 95% CI)	0.71 [0.59, 0.85]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	18	8391	Risk Ratio (IV, Random, 95% CI)	0.54 [0.44, 0.67]
7.1 Hospital setting	18	8391	Risk Ratio (IV, Random, 95% CI)	0.54 [0.44, 0.67]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	17	8690	Mean Difference (IV, Random, 95% CI)	-87.26 [-157.83, -16.69]
8.1 Hospital setting	17	8690	Mean Difference (IV, Random, 95% CI)	-87.26 [-157.83, -16.69]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	15	7929	Mean Difference (IV, Random, 95% CI)	-2.59 [-3.70, -1.48]
9.1 Hospital setting	15	7929	Mean Difference (IV, Random, 95% CI)	-2.59 [-3.70, -1.48]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	7	3798	Risk Ratio (IV, Random, 95% CI)	2.21 [1.19, 4.10]
11.1 Hospital setting	7	3798	Risk Ratio (IV, Random, 95% CI)	2.21 [1.19, 4.10]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	11	6718	Risk Ratio (IV, Random, 95% CI)	2.24 [1.52, 3.31]
12.1 Hospital setting	11	6718	Risk Ratio (IV, Random, 95% CI)	2.24 [1.52, 3.31]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	2	303	Risk Ratio (IV, Random, 95% CI)	1.26 [0.26, 6.23]
13.1 Hospital setting	2	303	Risk Ratio (IV, Random, 95% CI)	1.26 [0.26, 6.23]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	1	366	Risk Ratio (IV, Random, 95% CI)	1.93 [1.01, 3.67]
14.1 Hospital setting	1	366	Risk Ratio (IV, Random, 95% CI)	1.93 [1.01, 3.67]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	19	9458	Risk Ratio (IV, Random, 95% CI)	3.38 [2.50, 4.57]
16.1 Hospital setting	19	9458	Risk Ratio (IV, Random, 95% CI)	3.38 [2.50, 4.57]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	17	8607	Risk Ratio (IV, Random, 95% CI)	2.99 [2.00, 4.45]
17.1 Hospital setting	17	8607	Risk Ratio (IV, Random, 95% CI)	2.99 [2.00, 4.45]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	7	5649	Risk Ratio (IV, Random, 95% CI)	2.08 [0.99, 4.38]
18.1 Hospital setting	7	5649	Risk Ratio (IV, Random, 95% CI)	2.08 [0.99, 4.38]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 70. Injectable prostaglandins vs Misoprostol (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	170	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
2.1 Hospital setting	2	170	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	4	403	Risk Ratio (IV, Random, 95% CI)	0.88 [0.14, 5.39]
3.1 Hospital setting	4	403	Risk Ratio (IV, Random, 95% CI)	0.88 [0.14, 5.39]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	3	303	Risk Ratio (IV, Random, 95% CI)	1.60 [0.57, 4.52]
6.1 Hospital setting	3	303	Risk Ratio (IV, Random, 95% CI)	1.60 [0.57, 4.52]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	4	403	Risk Ratio (IV, Random, 95% CI)	1.02 [0.28, 3.69]
7.1 Hospital setting	4	403	Risk Ratio (IV, Random, 95% CI)	1.02 [0.28, 3.69]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	3	270	Mean Difference (IV, Random, 95% CI)	52.99 [-39.74, 145.71]
8.1 Hospital setting	3	270	Mean Difference (IV, Random, 95% CI)	52.99 [-39.74, 145.71]

8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	2	220	Mean Difference (IV, Random, 95% CI)	2.28 [-1.35, 5.90]
9.1 Hospital setting	2	220	Mean Difference (IV, Random, 95% CI)	2.28 [-1.35, 5.90]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	2	233	Risk Ratio (IV, Random, 95% CI)	0.23 [0.06, 0.92]
11.1 Hospital setting	2	233	Risk Ratio (IV, Random, 95% CI)	0.23 [0.06, 0.92]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	2	233	Risk Ratio (IV, Random, 95% CI)	1.31 [0.01, 163.15]
12.1 Hospital setting	2	233	Risk Ratio (IV, Random, 95% CI)	1.31 [0.01, 163.15]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	2	233	Risk Ratio (IV, Random, 95% CI)	0.99 [0.20, 4.80]
14.1 Hospital setting	2	233	Risk Ratio (IV, Random, 95% CI)	0.99 [0.20, 4.80]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	3	353	Risk Ratio (IV, Random, 95% CI)	0.04 [0.01, 0.21]
16.1 Hospital setting	3	353	Risk Ratio (IV, Random, 95% CI)	0.04 [0.01, 0.21]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	2	233	Risk Ratio (IV, Random, 95% CI)	0.08 [0.01, 0.39]
17.1 Hospital setting	2	233	Risk Ratio (IV, Random, 95% CI)	0.08 [0.01, 0.39]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	2	233	Risk Ratio (IV, Random, 95% CI)	9.03 [1.70, 48.00]
18.1 Hospital setting	2	233	Risk Ratio (IV, Random, 95% CI)	9.03 [1.70, 48.00]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 71. Misoprostol vs Carbetocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	177	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	1	177	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	177	Risk Ratio (IV, Random, 95% CI)	2.31 [0.62, 8.64]
2.1 Hospital setting	1	177	Risk Ratio (IV, Random, 95% CI)	2.31 [0.62, 8.64]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	1	177	Risk Ratio (IV, Random, 95% CI)	2.97 [0.12, 71.85]

3.1 Hospital setting	1	177	Risk Ratio (IV, Random, 95% CI)	2.97 [0.12, 71.85]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	177	Risk Ratio (IV, Random, 95% CI)	2.31 [1.52, 3.50]
6.1 Hospital setting	1	177	Risk Ratio (IV, Random, 95% CI)	2.31 [1.52, 3.50]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	1	177	Risk Ratio (IV, Random, 95% CI)	3.96 [1.55, 10.07]
7.1 Hospital setting	1	177	Risk Ratio (IV, Random, 95% CI)	3.96 [1.55, 10.07]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	177	Risk Ratio (IV, Random, 95% CI)	0.99 [0.47, 2.08]
11.1 Hospital setting	1	177	Risk Ratio (IV, Random, 95% CI)	0.99 [0.47, 2.08]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	1	177	Risk Ratio (IV, Random, 95% CI)	1.48 [0.55, 3.99]
12.1 Hospital setting	1	177	Risk Ratio (IV, Random, 95% CI)	1.48 [0.55, 3.99]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	1	177	Risk Ratio (IV, Random, 95% CI)	1.19 [0.71, 1.99]
13.1 Hospital setting	1	177	Risk Ratio (IV, Random, 95% CI)	1.19 [0.71, 1.99]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	1	177	Risk Ratio (IV, Random, 95% CI)	0.65 [0.52, 0.80]
14.1 Hospital setting	1	177	Risk Ratio (IV, Random, 95% CI)	0.65 [0.52, 0.80]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	1	177	Risk Ratio (IV, Random, 95% CI)	3.46 [1.67, 7.17]
16.1 Hospital setting	1	177	Risk Ratio (IV, Random, 95% CI)	3.46 [1.67, 7.17]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	1	177	Risk Ratio (IV, Random, 95% CI)	2.55 [1.41, 4.64]
17.1 Hospital setting	1	177	Risk Ratio (IV, Random, 95% CI)	2.55 [1.41, 4.64]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

20 Maternal satisfaction	0	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 72. Ergometrine vs Misoprostol (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	7	5254	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	6	4054	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	1	1200	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	11	5562	Risk Ratio (IV, Random, 95% CI)	1.25 [0.45, 3.48]
2.1 Hospital setting	10	4362	Risk Ratio (IV, Random, 95% CI)	1.42 [0.47, 4.34]
2.2 Community setting	1	1200	Risk Ratio (IV, Random, 95% CI)	0.33 [0.01, 8.17]
3 Blood transfusion	13	5308	Risk Ratio (IV, Random, 95% CI)	1.71 [0.65, 4.50]
3.1 Hospital setting	12	4108	Risk Ratio (IV, Random, 95% CI)	2.02 [0.73, 5.57]
3.2 Community setting	1	1200	Risk Ratio (IV, Random, 95% CI)	0.33 [0.01, 8.17]
4 Severe maternal morbidity: intensive care admissions	1	864	Risk Ratio (IV, Random, 95% CI)	0.33 [0.01, 8.16]
4.1 Hospital setting	1	864	Risk Ratio (IV, Random, 95% CI)	0.33 [0.01, 8.16]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	16	6459	Risk Ratio (IV, Random, 95% CI)	1.18 [0.79, 1.75]
6.1 Hospital setting	15	5259	Risk Ratio (IV, Random, 95% CI)	1.17 [0.77, 1.79]
6.2 Community setting	1	1200	Risk Ratio (IV, Random, 95% CI)	1.25 [0.34, 4.63]
7 Additional uterotonics	16	6565	Risk Ratio (IV, Random, 95% CI)	1.04 [0.68, 1.60]
7.1 Hospital setting	15	5365	Risk Ratio (IV, Random, 95% CI)	1.06 [0.68, 1.65]
7.2 Community setting	1	1200	Risk Ratio (IV, Random, 95% CI)	0.75 [0.17, 3.34]
8 Blood loss	15	6337	Mean Difference (IV, Random, 95% CI)	11.66 [-9.85, 33.17]
8.1 Hospital setting	14	5137	Mean Difference (IV, Random, 95% CI)	6.55 [-11.42, 24.51]
8.2 Community setting	1	1200	Mean Difference (IV, Random, 95% CI)	71.30 [60.86, 81.74]
9 Change in haemoglobin	8	4438	Mean Difference (IV, Random, 95% CI)	0.91 [-0.43, 2.26]
9.1 Hospital setting	8	4438	Mean Difference (IV, Random, 95% CI)	0.91 [-0.43, 2.26]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	13	5202	Risk Ratio (IV, Random, 95% CI)	1.53 [1.15, 2.04]
11.1 Hospital setting	12	4002	Risk Ratio (IV, Random, 95% CI)	1.43 [1.02, 2.00]
11.2 Community setting	1	1200	Risk Ratio (IV, Random, 95% CI)	1.98 [1.49, 2.64]
12 Vomiting	14	6136	Risk Ratio (IV, Random, 95% CI)	1.22 [0.81, 1.83]
12.1 Hospital setting	13	4936	Risk Ratio (IV, Random, 95% CI)	1.26 [0.77, 2.05]
12.2 Community setting	1	1200	Risk Ratio (IV, Random, 95% CI)	1.13 [0.70, 1.83]
13 Headache	8	3369	Risk Ratio (IV, Random, 95% CI)	1.70 [0.70, 4.12]
13.1 Hospital setting	8	3369	Risk Ratio (IV, Random, 95% CI)	1.70 [0.70, 4.12]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

14 Abdominal pain	2	233	Risk Ratio (IV, Random, 95% CI)	1.58 [0.04, 65.80]
14.1 Hospital setting	2	233	Risk Ratio (IV, Random, 95% CI)	1.58 [0.04, 65.80]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	2	300	Risk Ratio (IV, Random, 95% CI)	7.55 [0.94, 60.53]
15.1 Hospital setting	2	300	Risk Ratio (IV, Random, 95% CI)	7.55 [0.94, 60.53]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	17	6860	Risk Ratio (IV, Random, 95% CI)	0.34 [0.26, 0.44]
16.1 Hospital setting	16	5660	Risk Ratio (IV, Random, 95% CI)	0.31 [0.22, 0.44]
16.2 Community setting	1	1200	Risk Ratio (IV, Random, 95% CI)	0.39 [0.33, 0.47]
17 Fever	14	6330	Risk Ratio (IV, Random, 95% CI)	0.24 [0.17, 0.33]
17.1 Hospital setting	13	5130	Risk Ratio (IV, Random, 95% CI)	0.20 [0.15, 0.28]
17.2 Community setting	1	1200	Risk Ratio (IV, Random, 95% CI)	0.45 [0.29, 0.70]
18 Diarrhoea	8	4165	Risk Ratio (IV, Random, 95% CI)	1.04 [0.46, 2.34]
18.1 Hospital setting	8	4165	Risk Ratio (IV, Random, 95% CI)	1.04 [0.46, 2.34]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 73. Misoprostol vs Ergometrine plus oxytocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	4	3258	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	4	3258	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	9	6028	Risk Ratio (IV, Random, 95% CI)	1.61 [1.08, 2.40]
2.1 Hospital setting	9	6028	Risk Ratio (IV, Random, 95% CI)	1.61 [1.08, 2.40]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	8	6335	Risk Ratio (IV, Random, 95% CI)	1.41 [0.91, 2.21]
3.1 Hospital setting	8	6335	Risk Ratio (IV, Random, 95% CI)	1.41 [0.91, 2.21]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	10	6492	Risk Ratio (IV, Random, 95% CI)	1.75 [1.35, 2.26]
6.1 Hospital setting	10	6492	Risk Ratio (IV, Random, 95% CI)	1.75 [1.35, 2.26]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	9	6395	Risk Ratio (IV, Random, 95% CI)	1.87 [1.49, 2.36]
7.1 Hospital setting	9	6395	Risk Ratio (IV, Random, 95% CI)	1.87 [1.49, 2.36]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

8 Blood loss	8	5634	Mean Difference (IV, Random, 95% CI)	22.86 [4.50, 41.22]
8.1 Hospital setting	8	5634	Mean Difference (IV, Random, 95% CI)	22.86 [4.50, 41.22]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	9	5588	Mean Difference (IV, Random, 95% CI)	1.09 [-0.49, 2.67]
9.1 Hospital setting	9	5588	Mean Difference (IV, Random, 95% CI)	1.09 [-0.49, 2.67]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	4	3399	Risk Ratio (IV, Random, 95% CI)	0.71 [0.61, 0.84]
11.1 Hospital setting	4	3399	Risk Ratio (IV, Random, 95% CI)	0.71 [0.61, 0.84]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	6	4983	Risk Ratio (IV, Random, 95% CI)	0.72 [0.50, 1.04]
12.1 Hospital setting	6	4983	Risk Ratio (IV, Random, 95% CI)	0.72 [0.50, 1.04]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	3	3259	Risk Ratio (IV, Random, 95% CI)	0.91 [0.47, 1.76]
13.1 Hospital setting	3	3259	Risk Ratio (IV, Random, 95% CI)	0.91 [0.47, 1.76]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	1	846	Risk Ratio (IV, Random, 95% CI)	0.90 [0.79, 1.02]
14.1 Hospital setting	1	846	Risk Ratio (IV, Random, 95% CI)	0.90 [0.79, 1.02]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	3	2553	Risk Ratio (IV, Random, 95% CI)	0.50 [0.18, 1.41]
15.1 Hospital setting	3	2553	Risk Ratio (IV, Random, 95% CI)	0.50 [0.18, 1.41]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	6	4980	Risk Ratio (IV, Random, 95% CI)	2.71 [1.95, 3.76]
16.1 Hospital setting	6	4980	Risk Ratio (IV, Random, 95% CI)	2.71 [1.95, 3.76]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	7	5045	Risk Ratio (IV, Random, 95% CI)	5.33 [2.87, 9.88]
17.1 Hospital setting	7	5045	Risk Ratio (IV, Random, 95% CI)	5.33 [2.87, 9.88]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	6	3659	Risk Ratio (IV, Random, 95% CI)	1.04 [0.68, 1.57]
18.1 Hospital setting	6	3659	Risk Ratio (IV, Random, 95% CI)	1.04 [0.68, 1.57]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	1		Mean Difference (IV, Fixed, 95% CI)	Totals not selected
20.1 Hospital setting	1		Mean Difference (IV, Fixed, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Mean Difference (IV, Fixed, 95% CI)	0.0 [0.0, 0.0]

Comparison 74. Misoprostol vs Misoprostol plus oxytocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	1589	Risk Ratio (IV, Random, 95% CI)	1.85 [1.03, 3.33]
2.1 Hospital setting	2	1589	Risk Ratio (IV, Random, 95% CI)	1.85 [1.03, 3.33]

2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	2	1589	Risk Ratio (IV, Random, 95% CI)	2.97 [1.40, 6.30]
3.1 Hospital setting	2	1589	Risk Ratio (IV, Random, 95% CI)	2.97 [1.40, 6.30]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	2	1589	Risk Ratio (IV, Random, 95% CI)	1.93 [0.99, 3.76]
6.1 Hospital setting	2	1589	Risk Ratio (IV, Random, 95% CI)	1.93 [0.99, 3.76]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	3	1689	Risk Ratio (IV, Random, 95% CI)	1.89 [1.26, 2.83]
7.1 Hospital setting	3	1689	Risk Ratio (IV, Random, 95% CI)	1.89 [1.26, 2.83]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	1	792	Mean Difference (IV, Random, 95% CI)	48.0 [24.68, 71.32]
8.1 Hospital setting	1	792	Mean Difference (IV, Random, 95% CI)	48.0 [24.68, 71.32]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	3	1689	Mean Difference (IV, Random, 95% CI)	0.27 [-0.42, 0.96]
9.1 Hospital setting	3	1689	Mean Difference (IV, Random, 95% CI)	0.27 [-0.42, 0.96]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	100	Risk Ratio (IV, Random, 95% CI)	1.83 [0.73, 4.57]
11.1 Hospital setting	1	100	Risk Ratio (IV, Random, 95% CI)	1.83 [0.73, 4.57]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	3	1689	Risk Ratio (IV, Random, 95% CI)	1.39 [0.51, 3.82]
12.1 Hospital setting	3	1689	Risk Ratio (IV, Random, 95% CI)	1.39 [0.51, 3.82]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	3	1689	Risk Ratio (IV, Random, 95% CI)	0.94 [0.72, 1.22]
16.1 Hospital setting	3	1689	Risk Ratio (IV, Random, 95% CI)	0.94 [0.72, 1.22]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	3	1689	Risk Ratio (IV, Random, 95% CI)	0.97 [0.62, 1.53]
17.1 Hospital setting	3	1689	Risk Ratio (IV, Random, 95% CI)	0.97 [0.62, 1.53]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	2	1589	Risk Ratio (IV, Random, 95% CI)	1.22 [0.70, 2.13]
18.1 Hospital setting	2	1589	Risk Ratio (IV, Random, 95% CI)	1.22 [0.70, 2.13]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

19.1 Hospital setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 75. Carbetocin vs Injectable prostaglandins (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

13.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 76. Injectable prostaglandins vs Ergometrine (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	1	100	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	1	50	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
2.1 Hospital setting	1	50	Risk Ratio (IV, Random, 95% CI)	5.0 [0.25, 99.16]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	4	384	Risk Ratio (IV, Random, 95% CI)	1.01 [0.04, 23.58]
3.1 Hospital setting	4	384	Risk Ratio (IV, Random, 95% CI)	1.01 [0.04, 23.58]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	3	399	Risk Ratio (IV, Random, 95% CI)	1.42 [0.64, 3.17]
6.1 Hospital setting	3	399	Risk Ratio (IV, Random, 95% CI)	1.42 [0.64, 3.17]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	5	684	Risk Ratio (IV, Random, 95% CI)	0.78 [0.40, 1.51]

7.1 Hospital setting	5	684	Risk Ratio (IV, Random, 95% CI)	0.78 [0.40, 1.51]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	8	1195	Mean Difference (IV, Random, 95% CI)	-16.08 [-57.17, 25.00]
8.1 Hospital setting	8	1195	Mean Difference (IV, Random, 95% CI)	-16.08 [-57.17, 25.00]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	2	300	Mean Difference (IV, Random, 95% CI)	-1.28 [-6.58, 4.01]
9.1 Hospital setting	2	300	Mean Difference (IV, Random, 95% CI)	-1.28 [-6.58, 4.01]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	5	684	Risk Ratio (IV, Random, 95% CI)	1.70 [0.98, 2.94]
11.1 Hospital setting	5	684	Risk Ratio (IV, Random, 95% CI)	1.70 [0.98, 2.94]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	5	684	Risk Ratio (IV, Random, 95% CI)	2.70 [0.97, 7.55]
12.1 Hospital setting	5	684	Risk Ratio (IV, Random, 95% CI)	2.70 [0.97, 7.55]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	1	80	Risk Ratio (IV, Random, 95% CI)	2.0 [0.39, 10.31]
13.1 Hospital setting	1	80	Risk Ratio (IV, Random, 95% CI)	2.0 [0.39, 10.31]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	3	384	Risk Ratio (IV, Random, 95% CI)	1.70 [0.07, 40.44]
14.1 Hospital setting	3	384	Risk Ratio (IV, Random, 95% CI)	1.70 [0.07, 40.44]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	2	315	Risk Ratio (IV, Random, 95% CI)	0.16 [0.02, 1.37]
15.1 Hospital setting	2	315	Risk Ratio (IV, Random, 95% CI)	0.16 [0.02, 1.37]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	3	434	Risk Ratio (IV, Random, 95% CI)	0.38 [0.16, 0.91]
16.1 Hospital setting	3	434	Risk Ratio (IV, Random, 95% CI)	0.38 [0.16, 0.91]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	4	534	Risk Ratio (IV, Random, 95% CI)	4.52 [0.76, 26.80]
17.1 Hospital setting	4	534	Risk Ratio (IV, Random, 95% CI)	4.52 [0.76, 26.80]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	5	664	Risk Ratio (IV, Random, 95% CI)	10.09 [2.75, 37.00]
18.1 Hospital setting	5	664	Risk Ratio (IV, Random, 95% CI)	10.09 [2.75, 37.00]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 77. Injectable prostaglandins vs Ergometrine plus oxytocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	598	Risk Ratio (IV, Random, 95% CI)	0.80 [0.17, 3.78]
2.1 Hospital setting	2	598	Risk Ratio (IV, Random, 95% CI)	0.80 [0.17, 3.78]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	1	69	Risk Ratio (IV, Random, 95% CI)	0.65 [0.17, 2.53]
3.1 Hospital setting	1	69	Risk Ratio (IV, Random, 95% CI)	0.65 [0.17, 2.53]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	2	598	Risk Ratio (IV, Random, 95% CI)	1.29 [0.92, 1.79]
6.1 Hospital setting	2	598	Risk Ratio (IV, Random, 95% CI)	1.29 [0.92, 1.79]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	1	112	Risk Ratio (IV, Random, 95% CI)	1.07 [0.16, 7.36]
7.1 Hospital setting	1	112	Risk Ratio (IV, Random, 95% CI)	1.07 [0.16, 7.36]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	2	598	Mean Difference (IV, Random, 95% CI)	-26.18 [-104.63, 52.27]
8.1 Hospital setting	2	598	Mean Difference (IV, Random, 95% CI)	-26.18 [-104.63, 52.27]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	529	Risk Ratio (IV, Random, 95% CI)	5.06 [1.12, 22.86]
11.1 Hospital setting	1	529	Risk Ratio (IV, Random, 95% CI)	5.06 [1.12, 22.86]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	1	529	Risk Ratio (IV, Random, 95% CI)	0.92 [0.40, 2.13]
12.1 Hospital setting	1	529	Risk Ratio (IV, Random, 95% CI)	0.92 [0.40, 2.13]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	2	641	Risk Ratio (IV, Random, 95% CI)	23.70 [7.55, 74.45]
18.1 Hospital setting	2	641	Risk Ratio (IV, Random, 95% CI)	23.70 [7.55, 74.45]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 78. Misoprostol plus oxytocin vs Injectable prostaglandins (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]

9.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 79. Ergometrine vs Carbetocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

20.2 Community setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 80. Carbetocin vs Ergometrine plus oxytocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	2	320	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	2	320	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	4	1210	Risk Ratio (IV, Random, 95% CI)	0.34 [0.13, 0.86]
2.1 Hospital setting	4	1210	Risk Ratio (IV, Random, 95% CI)	0.34 [0.13, 0.86]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	4	1030	Risk Ratio (IV, Random, 95% CI)	1.42 [0.42, 4.82]
3.1 Hospital setting	4	1030	Risk Ratio (IV, Random, 95% CI)	1.42 [0.42, 4.82]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	2	320	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	2	320	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	4	1030	Risk Ratio (IV, Random, 95% CI)	0.96 [0.44, 2.09]
6.1 Hospital setting	4	1030	Risk Ratio (IV, Random, 95% CI)	0.96 [0.44, 2.09]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	6	1530	Risk Ratio (IV, Random, 95% CI)	0.54 [0.30, 1.00]
7.1 Hospital setting	6	1530	Risk Ratio (IV, Random, 95% CI)	0.54 [0.30, 1.00]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	5	1330	Mean Difference (IV, Random, 95% CI)	-44.08 [-82.41, -5.75]
8.1 Hospital setting	5	1330	Mean Difference (IV, Random, 95% CI)	-44.08 [-82.41, -5.75]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	5	1160	Mean Difference (IV, Random, 95% CI)	-2.57 [-4.32, -0.82]
9.1 Hospital setting	5	1160	Mean Difference (IV, Random, 95% CI)	-2.57 [-4.32, -0.82]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	6	1530	Risk Ratio (IV, Random, 95% CI)	0.29 [0.19, 0.45]
11.1 Hospital setting	6	1530	Risk Ratio (IV, Random, 95% CI)	0.29 [0.19, 0.45]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	6	1530	Risk Ratio (IV, Random, 95% CI)	0.27 [0.16, 0.46]
12.1 Hospital setting	6	1530	Risk Ratio (IV, Random, 95% CI)	0.27 [0.16, 0.46]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	5	1330	Risk Ratio (IV, Random, 95% CI)	1.41 [0.45, 4.38]
13.1 Hospital setting	5	1330	Risk Ratio (IV, Random, 95% CI)	1.41 [0.45, 4.38]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

14 Abdominal pain	4	930	Risk Ratio (IV, Random, 95% CI)	0.57 [0.36, 0.91]
14.1 Hospital setting	4	930	Risk Ratio (IV, Random, 95% CI)	0.57 [0.36, 0.91]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	3	660	Risk Ratio (IV, Random, 95% CI)	0.56 [0.22, 1.39]
15.1 Hospital setting	3	660	Risk Ratio (IV, Random, 95% CI)	0.56 [0.22, 1.39]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	5	1290	Risk Ratio (IV, Random, 95% CI)	0.45 [0.26, 0.80]
16.1 Hospital setting	5	1290	Risk Ratio (IV, Random, 95% CI)	0.45 [0.26, 0.80]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 81. Misoprostol plus oxytocin vs Carbetocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	1	380	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	1	380	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	1	380	Risk Ratio (IV, Random, 95% CI)	4.00 [0.45, 35.46]
3.1 Hospital setting	1	380	Risk Ratio (IV, Random, 95% CI)	4.00 [0.45, 35.46]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	1	380	Risk Ratio (IV, Random, 95% CI)	1.19 [0.74, 1.93]
7.1 Hospital setting	1	380	Risk Ratio (IV, Random, 95% CI)	1.19 [0.74, 1.93]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	1	380	Mean Difference (IV, Random, 95% CI)	-1.70 [-3.72, 0.32]
9.1 Hospital setting	1	380	Mean Difference (IV, Random, 95% CI)	-1.70 [-3.72, 0.32]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	1	380	Risk Ratio (IV, Random, 95% CI)	1.21 [0.62, 2.39]
11.1 Hospital setting	1	380	Risk Ratio (IV, Random, 95% CI)	1.21 [0.62, 2.39]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	1	380	Risk Ratio (IV, Random, 95% CI)	1.33 [0.58, 3.09]
12.1 Hospital setting	1	380	Risk Ratio (IV, Random, 95% CI)	1.33 [0.58, 3.09]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	1	380	Risk Ratio (IV, Random, 95% CI)	2.0 [0.37, 10.79]
13.1 Hospital setting	1	380	Risk Ratio (IV, Random, 95% CI)	2.0 [0.37, 10.79]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	1	380	Risk Ratio (IV, Random, 95% CI)	7.83 [3.43, 17.88]
16.1 Hospital setting	1	380	Risk Ratio (IV, Random, 95% CI)	7.83 [3.43, 17.88]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	1	380	Risk Ratio (IV, Random, 95% CI)	8.5 [1.99, 36.28]
17.1 Hospital setting	1	380	Risk Ratio (IV, Random, 95% CI)	8.5 [1.99, 36.28]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 82. Ergometrine vs Ergometrine plus oxytocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	1	144	Risk Ratio (IV, Random, 95% CI)	0.17 [0.01, 4.06]
6.1 Hospital setting	1	144	Risk Ratio (IV, Random, 95% CI)	0.17 [0.01, 4.06]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	1	144	Mean Difference (IV, Random, 95% CI)	20.10 [5.76, 34.44]
8.1 Hospital setting	1	144	Mean Difference (IV, Random, 95% CI)	20.10 [5.76, 34.44]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected

19.1 Hospital setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0	Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 83. Misoprostol plus oxytocin vs Ergometrine (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.1 Hospital setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

13.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Comparison 84. Misoprostol plus oxytocin vs Ergometrine plus oxytocin (by healthcare setting)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Death	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2 PPH >= 1000 mL	2	1605	Risk Ratio (IV, Random, 95% CI)	1.41 [0.68, 2.94]
2.1 Hospital setting	2	1605	Risk Ratio (IV, Random, 95% CI)	1.41 [0.68, 2.94]
2.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Blood transfusion	2	1605	Risk Ratio (IV, Random, 95% CI)	0.89 [0.36, 2.19]
3.1 Hospital setting	2	1605	Risk Ratio (IV, Random, 95% CI)	0.89 [0.36, 2.19]
3.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Severe maternal morbidity: intensive care admissions	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5 Severe maternal morbidity: shock	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
5.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 PPH >= 500 mL	2	1605	Risk Ratio (IV, Random, 95% CI)	1.39 [0.65, 2.99]
6.1 Hospital setting	2	1605	Risk Ratio (IV, Random, 95% CI)	1.39 [0.65, 2.99]
6.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
7 Additional uterotonics	2	1605	Risk Ratio (IV, Random, 95% CI)	1.48 [0.82, 2.69]

7.1 Hospital setting	2	1605	Risk Ratio (IV, Random, 95% CI)	1.48 [0.82, 2.69]
7.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
8 Blood loss	1	802	Mean Difference (IV, Random, 95% CI)	-16.0 [-40.24, 8.24]
8.1 Hospital setting	1	802	Mean Difference (IV, Random, 95% CI)	-16.0 [-40.24, 8.24]
8.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
9 Change in haemoglobin	2	1605	Mean Difference (IV, Random, 95% CI)	-0.50 [-1.72, 0.72]
9.1 Hospital setting	2	1605	Mean Difference (IV, Random, 95% CI)	-0.50 [-1.72, 0.72]
9.2 Community setting	0	0	Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10 Breastfeeding	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
10.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11 Nausea	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
11.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
12 Vomiting	2	1605	Risk Ratio (IV, Random, 95% CI)	1.04 [0.23, 4.77]
12.1 Hospital setting	2	1605	Risk Ratio (IV, Random, 95% CI)	1.04 [0.23, 4.77]
12.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13 Headache	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
13.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14 Abdominal pain	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
14.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15 Hypertension	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.1 Hospital setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
15.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
16 Shivering	2	1605	Risk Ratio (IV, Random, 95% CI)	2.95 [2.02, 4.29]
16.1 Hospital setting	2	1605	Risk Ratio (IV, Random, 95% CI)	2.95 [2.02, 4.29]
16.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
17 Fever	2	1605	Risk Ratio (IV, Random, 95% CI)	2.89 [1.51, 5.54]
17.1 Hospital setting	2	1605	Risk Ratio (IV, Random, 95% CI)	2.89 [1.51, 5.54]
17.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
18 Diarrhoea	2	1605	Risk Ratio (IV, Random, 95% CI)	0.81 [0.46, 1.41]
18.1 Hospital setting	2	1605	Risk Ratio (IV, Random, 95% CI)	0.81 [0.46, 1.41]
18.2 Community setting	0	0	Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19 Maternal well-being	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
19.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
19.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20 Maternal satisfaction	0		Risk Ratio (IV, Random, 95% CI)	Totals not selected
20.1 Hospital setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]
20.2 Community setting	0		Risk Ratio (IV, Random, 95% CI)	0.0 [0.0, 0.0]

WHAT'S NEW

Date	Event	Description
24 May 2018	New search has been performed	Search updated. We have included 56 new trials in this update involving 46,612 women. We have updated the methods - all changes are summarised in detail in 'Differences between protocol and review'. Six authors have stepped down from the team and 10 new authors have joined the review team
24 May 2018	New citation required but conclusions have not changed	With the addition of 56 new trials (46,612 women), the update now includes a total of 196 trials (135,559 women). The conclusions remain largely the same The results for the primary outcome of postpartum haemorrhage (PPH) ≥ 500 mL were similar to the previously published review (Gallos 2018), although the quality of the evidence for carbetocin has changed from 'very low-certainly' to 'moderate-certainty evidence' for this outcome, due to the addition of data from three studies including approximately 30,000 women. For the primary outcome of PPH ≥ 1000 mL, none of the agents is significantly more effective when compared with the reference uterotonic agent oxytocin. In the previous version of the review, high-quality evidence suggested that ergometrine plus oxytocin was more effective in reducing PPH ≥ 1000 mL in comparison to oxytocin. For all other outcomes (blood transfusion; additional uterotonics; and side effects), the results are largely the same

CONTRIBUTIONS OF AUTHORS

Ioannis D Gallos (IDG) and Arri Coomarasamy (AC) conceived the idea for this study. IDG, Malcolm J Price (MJP), Aurelio Tobias (AT), Olufemi T Oladapo (OTO) and AC designed the meta-analysis. IDG designed all electronic data collection forms. IDG, Argyro Papadopoulou (AP), Rebecca Man (RM), Nikos Athanasopoulos (NA) screened trials and extracted data. MJP and AT performed the statistical analysis. Myfanwy Williams (MJW), Virginia Diaz (VD), Julia Pasquale (JP), Monica Chamillard (MC), Josh Vogel (JPV) and OTO graded the evidence and created the 'summary of findings' tables. IDG drafted the protocol and all versions of the review. AP, RM, NA, MP, AT, MP, OT, MJW, VD, JP, MC, Mariana Widmer (MW), Özge Tuncalp (OT), G Justus Hofmeyr (GJH), Fernando Althabe (FA), A Metin Gulmezoglu (AMG), JPV, OTO and AC edited and revised the review.

DECLARATIONS OF INTEREST

Ioannis D Gallos (IDG): is a co-applicant to the UK National Institute for Health Research HTA Project Award 14/139/17 entitled *Uterotonic agents for preventing postpartum haemorrhage: a network meta-analysis and cost-effectiveness analysis*. He has been involved in one or more previous or ongoing trials related to the use of uterotonics for the prevention of PPH that were eligible for inclusion in this review. Ferring Pharmaceuticals and Novartis supplied carbetocin and oxytocin for these studies. IDG did not participate in any decisions regarding these trials (i.e. assessment for inclusion/exclusion, trial quality, data extraction) for the purposes of this review (and will not for future updates) - these tasks were carried out by other members of the team who were not directly involved in the trials.

Argyro Papadopoulou (AP): none known.

Rebecca Man (RM): none known.

Nikolaos Athanasopoulos (NA): none known.

Malcolm J Price (MJP): is a co-applicant to the UK National Institute for Health Research HTA Project Award 14/139/17 entitled *Uterotonic agents for preventing postpartum haemorrhage: a network meta-analysis and cost-effectiveness analysis*.

Aurelio Tobias: none known.

Myfanwy Williams (MJW): is employed by the University of Liverpool as a Research Associate at Cochrane Pregnancy and Childbirth. Her role is supported by the World Health Organization.

Virginia Diaz (VD): none known.

Julia Pasquale (JP): none known.

Monica Chamillard (MC): none known.

Mariana Widmer (MW): has been involved in a trial related to the use of uterotonics for the prevention of PPH that is included in this review. Ferring Pharmaceuticals and Novartis supplied carbetocin and oxytocin for the trial and the study is supported by WHO/Merck for Mothers. MW did not participate in any decisions regarding this trial (i.e. assessment for inclusion/exclusion, trial quality, data extraction) for the purposes of this review or future updates - these tasks were carried out by other members of the team who were not directly involved in the trial.

Özge Tunçalp (OT): is a co-applicant to the UK National Institute for Health Research HTA Project Award 14/139/17 entitled *Uterotonic agents for preventing postpartum haemorrhage: a network meta-analysis and cost-effectiveness analysis*.

G Justus Hofmeyr (GJH): has been and continues to be involved in a number of studies that may be eligible for inclusion in this review, but has not been (and will not participate in) data extraction or quality assessment of the studies in which he was involved. GJH is a co-investigator on the UK National Institute for Health Research HTA Project Award 14/139/17 entitled *Uterotonic agents for preventing postpartum haemorrhage: a network meta-analysis and cost-effectiveness analysis*. Neither he nor his institution receives funding from this grant.

Fernando Althabe: none known.

A Metin Gulmezoglu (AMG): was part of the central coordination unit of the large World Health Organization multicentre trial comparing carbetocin with oxytocin included in the review. He is a co-applicant to the UK National Institute for Health Research HTA Project Award 14/139/17 entitled *Uterotonic drugs for preventing postpartum haemorrhage: a network meta-analysis and cost-effectiveness analysis*.

Joshua Vogel (JPV): led the updating of *WHO recommendations on uterotonics for the prevention of postpartum haemorrhage* based on this review.

Olufemi T Oladapo (OTO): led the updating of *WHO recommendations on uterotonics for the prevention of postpartum haemorrhage* based on the findings of this review update.

Arri Coomarasamy (AC): is the Chief Investigator of UK National Institute for Health Research HTA Project Award 14/139/17 entitled *Uterotonic agents for preventing postpartum haemorrhage: a network meta-analysis and cost-effectiveness analysis*. He has been involved in one or more previous or ongoing trials related to the use of uterotonics for the prevention of PPH that were eligible for inclusion in this review. Ferring Pharmaceuticals and Novartis supplied carbetocin and oxytocin for these studies and another study is supported by WHO/Merck for Mothers. AC did not participate in any decisions regarding these trials (i.e. assessment for inclusion/exclusion,

trial quality, data extraction) for the purposes of this review or future updates - these tasks have been carried out by other members of the team who were not directly involved in the trials. AC is a member of the Executive Board of Ammalife (UK registered charity 1120236). He does not receive any payment for this relationship.

SOURCES OF SUPPORT

Internal sources

- University of Birmingham, UK.

The authors of this review are employed by the institutions indicated by their respective affiliations except where otherwise stated.

- World Health Organization, Switzerland.

The authors of this review are employed by the institutions indicated by their respective affiliations except where otherwise stated.

- University of the Witwatersrand, South Africa.

The authors of this review are employed by the institutions indicated by their respective affiliations except where otherwise stated.

External sources

- National Institute for Health Research, UK.

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DIFFERENCES BETWEEN PROTOCOL AND REVIEW

There are some differences between the published protocol for this review (Gallos 2015) and the full review, these are listed below.

Objectives

We have clarified the objectives of this review.

In our protocol the stated objectives were: "We aim to assess the clinical effectiveness and side-effect profile of uterotonic agents to prevent PPH, and to generate a clinically useful ranking of available uterotonics according to their effectiveness and side effects. We will explore the effects according to various key prognostic and treatment factors. The population of interest is women following a vaginal birth or a caesarean section in the hospital or the community setting. All uterotonic agents considered by the WHO are eligible and the outcomes include blood loss-related outcomes and side effects."

In the review, our objectives are listed as:

To identify the most effective uterotonic agent(s) to prevent PPH with the least side effects, and generate a ranking according to their effectiveness and side-effect profile.

Methods/types of interventions

The text in this section has been edited to add sensitivity analyses that became necessary during the review and explain how we grouped the agents for analysis.

In the protocol, this section stated:

"We will consider trials of uterotonics described by WHO (WHO 2012) (oxytocin, ergometrine, misoprostol, carbetocin, or combinations of uterotonics) administered prophylactically by healthcare professionals for preventing PPH via any systemic route (sublingual, subcutaneous, intramuscular, rectal, oral, intravenous bolus and/or infusion) compared with another uterotonic or with placebo or no treatment. If we identify in the included studies interventions that we are not aware of, we will consider them as eligible and include them in the network after assessing their comparability with those named above. We will include trials in which non-pharmacologic co-interventions such as controlled cord traction, cord clamping, or uterine massage was performed as a randomised intervention in all arms of the trial. We will stratify all agents according to mode of birth, prior risk of PPH, healthcare setting, specific dosage, regimen and route, to detect inequalities in subgroups that could affect comparative effectiveness."

Figure 1 (in the published protocol) shows the overall network of eligible comparisons in the review at the agent level.

"Multi-arm trials that compare different dosages, regimens or routes of one uterotonic agent, but also compare those versus another uterotonic agent, will be included. Intervention arms of different dosages, regimens or routes of the same uterotonic agent will be merged together for the global analysis of all outcomes and treated as separate independent comparisons only for the relevant subgroup analysis according to dosage, regimen and route of administration, while taking into account the correlation between the comparisons. We will exclude trials comparing exclusively different dosages, regimens or routes of administration of the same uterotonic agent. The review will be restricted to studies evaluating uterotonic agents administered systemically at the birth of the baby for preventing PPH. Studies considering non-uterotonic agents, uterotonic agents administered locally (for example, via intraumbilical or intrauterine routes) or at a later stage of delivery (for example, for the treatment of PPH or for retained placenta) will be excluded."

In our review this section now states:

Trials were eligible if they administered uterotonic agents of any dosage, route or regimen systemically at birth for preventing postpartum haemorrhage (PPH), and compared them with other uterotonic agents, placebo or no treatment. Trials evaluating uterotonic agents not administered systemically, such as intrauterine administration, or not immediately after birth, or exclusively comparing different dosages, routes or regimens of the same uterotonic agent were excluded. We included trials in which non-pharmacologic co-interventions such as controlled cord traction, cord clamping, or uterine massage was performed as a randomised intervention in all arms of the trial and the effects of such co-interventions were tested through a sensitivity analysis.

We classified agents into single agents including oxytocin, carbetocin, injectable prostaglandins (carboprost tromethamine, sulprostone), misoprostol, ergometrine (included also ergonovine, methylergonovine), and combination agents including ergometrine plus oxytocin (Syntometrine ® as a fixed-combination agent containing 5 international units (IU) of oxytocin and 500 mcg of ergometrine, any oxytocin dose and route when combined with any dose and route of ergometrine, ergonovine, or methylergonovine), and misoprostol plus oxytocin (any oxytocin dose and route when combined with any dose and route of misoprostol).

Methods/search methods

The search methods have been updated in line with the current standard search methods text of Cochrane Pregnancy and Childbirth.

Methods/types of outcomes/secondary outcomes

We have edited our outcome list based on the core outcome set for prevention of PPH. We have edited the composite outcome 'maternal deaths or severe morbidity events' and split that into 'severe maternal morbidity: 'intensive care admissions' and 'severe maternal morbidity: shock (as defined by the trialists)'. We have removed the outcomes 'manual removal of placenta'; 'mean durations of the third stage of labour (minutes)'; 'neonatal unit admission requirement'; 'tachycardia'; and 'hypotension'. We have added outcomes 'diarrhoea'; 'maternal sense of well-being (as defined by the trialists)'; 'maternal satisfaction (as defined by the trialists)'.

Assessment of reporting biases

We have edited the assessment of reporting biases. In the protocol, these sections stated:
We assessed potential reporting bias for the primary outcomes by assessing the sensitivity of results to exclusion of studies with fewer than 400 participants.
In our review these sections now state:
If there were 10 or more studies in the meta-analysis, we investigated reporting biases (such as publication bias) using funnel plots. The funnel plots were assessed visually for asymmetry. We also assessed potential reporting bias for the primary outcomes by assessing the sensitivity of results to exclusion of studies with fewer than 400 participants.

Methods/investigation of heterogeneity and inconsistency and also subgroup analysis

We have edited the intervention subgroups for exploring heterogeneity and inconsistency and also subgroup analysis. In the protocol, these sections stated:
Intervention: dose, regimen or route.
We assessed subgroup differences by firstly comparing the network diagram for each subgroup. Next, we performed a network meta-analysis for each subgroup and we compared their relative treatment effects and their relative treatment ranking.
In our review these sections now state:
Intervention: Dose of misoprostol ($\geq$ 600 mcg versus < 600 mcg), and regimen of oxytocin (bolus versus bolus plus infusion versus infusion only).
We assessed subgroup differences by firstly comparing the network diagram for each subgroup. Next, we performed a pairwise and network meta-analysis for each subgroup and we compared their relative treatment effects and their relative treatment ranking. We examined the subgroups for qualitative interactions where the direction of effect could be reversed, that is if an intervention was beneficial in one subgroup but harmful in another.

Methods/investigation of heterogeneity and inconsistency and also subgroup analysis

We have carried out additional sensitivity analyses that became necessary during the conduct of the review. These are listed below.

1. Trials that also randomised participants to co-interventions such as uterine massage or controlled cord traction.
2. Trials with more than 10% missing data.
3. Trials published before 1990.

Analysis

Since publication of the protocol for this review, further methods became available to perform the analysis with a frequentist approach in STATA. We changed our analysis for this reason to STATA rather than WinBUGS and a Bayesian environment.

'Summary of findings' table

We have modified our approach to assessing confidence in the evidence generated by this network meta-analysis, in line with recent guidance published by the GRADE working group (see Brignardello-Petersen 2018; Puhan 2014). This was not planned at the protocol stage, because we were not aware then of the most up-to-date guidance.

INDEX TERMS

Medical Subject Headings (MeSH)

*Network Meta-Analysis; Drug Therapy, Combination [adverse effects; methods]; Ergonovine [adverse effects; *therapeutic use]; Fever [chemically induced]; Hypertension [chemically induced]; Misoprostol [*therapeutic use]; Oxytocics [*therapeutic use]; Oxytocin [adverse effects; *analogs & derivatives; *therapeutic use]; Postpartum Hemorrhage [*prevention & control]; Vomiting [chemically induced]

MeSH check words

Female; Humans